State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year July 11, 2009 16:29 M JUAN C. RIVERA 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY SILVER SPRING HOLY CROSS HOSPITAL | If Under 1 Year | If Under 24 Hrs. | Min. | B. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) | February 2, | SALVADOR 7. Age (In vrs. last birthday 6. Sex 1 **X** M 2 □ F 51 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 □ No MARYLAND | MONTGOMERY SILVER SPRING 10g. Citizen of What Country? 10f. Zip Code EL SALVADOR 20902 1412 GLEASON STREET 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Specify: Hispanic 1 XNever Married 2 ☐ Married Specify: EL SALVADOR 1XYes 2□No If Yes, Give Year or Dates 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) maintenance building worker **Hebrew House** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) DOMITILA RIVERA PABLO LOPEZ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20902 19a. Informant's Name/Relationship (Type. Print) 1412 GLEASON STREET SILVER SPRING, MD Herbert D. Rivera (Brother) July Date 20, 2009 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation Heritage Memorial Cemetery Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Santa Cruz Funeral Services, Inc. 21. Signature of Funeral Servin 600 Kennedy Street, N.W.; Washington, D.C. 20011

should be filed within 72 hours after death with the Maryland and Mental Hygiene. permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinat must be rutified at once. Baltimore, Maryland 21215-0036 Pages 1 / Physician

**Physician** 

/Medical

Examiner

Director

Funeral

\$

Completed

Be

2

**Funeral** 

Director

5. Social Security Number

214-25-6911

10e. Street and Number

9

20a. Method of Disposition

11. Marital Status

/Medical Examiner physician and the burial-transit s been signed by the should be detached Division of Vital Records, P.O. After this certificate has funeral director, page 2 s Attending Physician; within 24 hours after death

To the Funeral Director:
completely filled in by the f the Hospital or

23a. Part 1. Enter the disease, or companies shock, or heart failure. List only	plications that caused the death. Do not enter the one cause on each line.	mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition	a Respiratory Fo	ilute			Chock and Dodan
resulting in death)	Due to (o as a consequence of				
Sequentially list conditions, if any, leading to immediate	b. Due to or as a consequence of):				
cause. Enter Underlying Cause (Disease or injury that initiated events	a Chronic Care T	)isease			
resulting in death) Last	Due to (or as a consequence of):				
	,d				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		pic pregnancy ar (s <i>pecify</i> )		23d. Date of del Month	ivery Day Year
Part II. Other significant conditions of	contributing to death but not resulting in the underly	ing cause given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
			1 ☐ Yes	2∏No 3∏Pi	robably 4 🗌 Unknown
			24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
25. Was case referred to medical		26. Place of Dea	th (Check only one)		
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 2 Inpatient 2 ☐ ER/Outpatient 3	□ DOA Other: 4 □ Nursing H	lome 5 Residence	6 ☐ Other (Spe	cify)
27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M	28c. Injury at Work?	28d. Describe how in		
3 Suicide 6 Could not by determined		actory, office	28f. Location (Street City or Town, Sta	and Number or Rate)	ural Route Number,
29a. Certifier  (Check only one)  Certifying Properties one)	nysician: To the best of my knowledge, death occu niner: On the basis of examination and/or investig and manner stated.	urred at the time, date and place ation, in my opinion, death occu	e, and due to the cause urred at the time, date a	e(s) and manner a and place, and due	s stated. e to the cause(s)
29b. Signature and title of certifier	//	29c. License number	29d. I	Date signed (Mont	h, Day, Year)
17/1/	Hamp	D67589	7/	12/20	09
30. Name and address of person who	completed cause of death (Item 23a) (Type, Print)				
/ HAROLD LA	completed cause of death (item 23a) (type, Print)    1500   Fore 2   32. Registrar's Signature	st GIEN Rd Sil	YER SPRING	MW 200	110
31. Date filed (Month, Day, Year)	32. Registrar's Signature				
JUL 1 7 2003 X	Rever A. parl				

Stat Registra 09-05330 Stepfon B. Robinson

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #State of Maryland Department Health and Mental Hygiene

	F	1- For State Certificate of Death Registrar		Reg.	No. 20	109 2450	
Physicia	ın/	1. Decedent's Name (First, Middle,Last)	M	ate of Death onth D	ay Year	3. Time of Death 0156 hrs	
Medical Examin		Stepfone B. Robinson  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location		ly 7, 2009	4c. County of		
<b>)</b>		1502 Accokeek Road Waldorf		Prince George's			
Funeral Director		578–11–6569 X M 2 F 23 Yrs. Months Days Ho		Date of Birth (	мм/dd/үүүү) 1985	9. Birthplace (State or Foreign Country) D.C.	
è	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits	
nd thow a	١	Md. Prince George's Fort Washington				1 X Yes 2 No	
Varyland 28a-f show any <u>d at once.</u>	Director	10e. Street and Number 10f. Zip Code		10g	. Citizen of Wha	· · · · ·	
th the Maryland 23a or 28a-f sho notified at once		12515 Languer Drive 20744		Van an Na	U.S.		
ter death wi	Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 X No specify Cuban, Mexi	kican, Puerto Rica		White,	American Indian, Black, etc. African– American	
2 hours af "natural Examin	g p	Lor Dates:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (G during most of working life. DO N	Give kind of work of	done 1	6b. Kind of Busi	ness/Industry	
36 n 72 h nan "n ical E	plete	Elementary/Secondary (0-12) College (1-4 or 5+)  10th Contractor	1401 400 1011100)		Const	ruction	
5-00% led with tygiene other t	Completed by	17. Father's Name (First, Middle, Last) 18.Mo	other's Name (Firs		iden Surname)		
21215-0036 buld be filed within ? Mental Hygiene. marked other than ic event, the Medica	B		Stephanio				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical	٩	19a. Informant's Name/Relationship (Type, Print)  Stephanie Robinson/Mother  19b. Mailing Address (Street and 12515 Languer Dr.)	r.,Ft. W	ashing	ton,Md.	20744	
nore, ages I and of Heal		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State crematory or other place)			20c. Location - 0	City or Town, State	
Baltimore, permit Pages I an Department of He Important: If ite		4 Donation 5 Other Specify: Lincoln Memorial Cem			Suitlan		
Balt permit Departs Import injury		21. Signature of Funeral Service Line See  22. Name and Address of Fa	ington & ahs Ave	Sons	Co.,Inc Washing	ton, D.C. 20019	
Physician	1	23a. Pag I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such failure. List only one cause on each line.	as cardiac or res	piratory arres	t, shock, or hear	rt Approximate Interval Between Onset and	
/Medical ( ;aminer		Immediate Cause (Final disease a. Gunshot Wounds (2) of Head				Death	
* *		or condition resulting in death)  Due to (or as a consequence of):  b.					
	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):					
ted   	Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.	<u>.</u>				
760, reate be executed physician and the burial - transit	Medical	UNPENDED AMENDED		-			
760, icate be physic the bur		IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the	·		23d. Date of o		
Box 68 e death certifi the attending ed for use as	ia.	past 12 months?  4 Pregnant at time of death 5 Other (Specify)	ctopic pregnancy		Month	Day Year	
Boy ne death the att	Physi	1 Yes 2 No 9 Unknown 9 Unknown	I- D-d	220 Did tob	Deep upo contrib	bute to the cause of death?	
Vital Records, P.O. B hysician: The law requires that the d this certificate has been signed by the Il director, page 2 should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	in Paπ I.			Probably 4 Unknown	
ds,   equires een sig	sted		- 3	24a. Was ar		Vere autopsy findings available	
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n of Vital Recing Physician: The lafter this certificate functal director, page	To B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other			Residence 6		
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the safer death.  al Director: After this certificate has been signed by lled in by the funeral director, page 2 should be detact		27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  28a. Date of Injury FOUND: 28b. Time of Injury FOUND: 1 Yes: 3	Sul	bject shot	ow injury occurre	D;	
Divisior Hospital or Attend 24 hours after death Funeral Director:	ertification:	3 Suicide 6 Could not be determined (Specify) Garage			reet and Numbe ate) k Road, Waldo	er or Rural Route Number, City orf , MD	
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be executed within 24 hours after death.  To the Innernal Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date an one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dea	and place, and due ath occurred at the	to the cause e time, date a	e(s) and manner and place, and de	as stated. ue to the cause(s)	
7 Wij. 7	Me	and manner stated.  29b. Signature and title of certifier  29c. License nun	ımber		29d. Date signe	ed (Month, Day, Year)	
		Canol Hellan O.C.M.E			July 7, 200	9 	
R2		30. Name and address of person who completed cause of death (Item 23a)  Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore,	, MD 21201				
S Regis	tate						
Regis	પાલા						

			For State Of State Of Registrar	Maryland / Depa Cer	artment of He rtificate of De			giene Reg. No. 2 (	09	24503
	hysicia		Decedent's Name (First, Middle, Last)     ANNA	MAE	RUFFIN		2. Date of Dea Month JULY	Day 200	Year 09	3. Time of Death 7:40 A <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give street and num 4613 SCHLEY AVENUE		4b. City, Town, or Lo	ORE		4c. County	y of Death	
	ineral rector		439-26-7813 1□ M 2X F	7. Age <i>(In yr</i> s. <i>l</i> as <i>t birthday)</i> Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da FEB 19	y, Year)	Coun	lace (State or Foreign htry) ORLEANS
Maryland	a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  MD	10c. City, Town or Local BALTIMOR					1	0d. Inside City Limits  X□Yes 2□No
with the	3a or 28	al Director	10e. Street and Number 4613 SCHLEY AVENUE	,	10f. Zip Code 21206			10g. Citizen of USA	What Coun	try?
5-0036 72 hours after death with the Maryland	n "natural", or items 23a or 28a-f show sedical Experiment must be rediffed at	by Funeral		2 <b>X</b> No e .	Was Decedent of Hisp f Yes, specify Cuban,	panic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Ra Bla Specia	ce - Americ ack, White, e	
	r than "natura Ine Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-	4or 5+) 16a. Deced	dent's Usual Occupation kind of work done dur DO NOT use retired)	on ing most of worki	ing	16b. Kind of E		dustry
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ard and	item 27 Is marked othe other traumatic event,	우	WILLIAM ROSS  19a. Informant's Name/Relationship (Type. Print)  SYLVIA RUFFIN/DAUGHTER		ng Address (Street and					
More, M Pages 1 and 2 nent of Health	nt: If item ? ry or other		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from S  4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo	sition (Name of natory or other place)		Date	20c. Location	- City or To	wn, State
baltimo permit. Pages Department of	Important: If it any Injury or c once.		21. Signature of Funeral Service Licensee	22	2. Name and Address	of Facility	J. B.	JENKINS	FUNE	RAL HOME
	sician	9		used the death. Do not ent	er the mode of dying,					Approximate Interval Between Onset and Death
	edical miner		ASP	or as a consequence of):  IRATION PNEUM	10NIA					
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DIVISION al or Attending s after death.	I Director:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place buildin	of Injury - At home, farm, str ng, etc. (Specify)			28f. Location (3 City or Tox		ber or Rura	al Route Number,
ne Hospit	e Funera	edical (	29a. Certifier (Check only one)  1X Certifying Physician: To the be and mann	asis of examination and/or in						
To th	<b>19 C</b>	Me	29b. Signature and title of certifier  S.H RW		29c. License r			29d. Date sign		
R	5		30. Name and address of person who completed cause	e of death (Item 23a) (Type,				JULY	15, 2	.007
	Sta Registra		STEVEN TEE, MD 3415 HAM 31. Date filed (Month, Day, Year)  JUL 1 6 2009	agistrar's Signature	LOVILLE, I	س کار/82				

09-05367 Kim David Rohrer Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1.	1- For State Registrar		•	Certific	ate of L	Death			R	eg. No.	400	7 5401
## Facility was just an elemental number of the property of t	an/ 1. Decedent's N	Name (First, Middle,Las	st)						Date of Dea     Month	th Day		3. Time of Death
Color Security Name   Security		avid Rohre	r									1030 hrs
Social Search Name   15.5 kg   2   5.5 kg   17. Age to pro. led bordery   100. Control   100.	4a. Facility Nam	me (if not institution, giv	e street and number)					tion of Death	1			
United Total Control of Control o	20800 Pa	'armar Drive				Oldtown						
10   10   10   10   10   10   10   10	5. Social Securi	rity Number 6. Se	ex 7. Age	(In yrs. last bi	rthday)				_		Cou	ntry)
To Summer   To Company   To C	220-70	)-5459	X <sub>M</sub> <sub>2</sub> F	52	Yrs.	Months	Days H	lours   Mir	9/11	/1956	Was	hington, DC
Name   Part	Usual Residence	nce of Decedent		-								
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200. Heaves of Disposition (Name of cemetery, 1987) and 1987 and 1	2 19a. Informant			1								
1	Kevin		rother							lan, l	Cation - City or	Town State
1	1 Burial		Removal from Sta	ite crem	atory or other	er place)					,	
Physician Modical Xaminer  23a. Fart. Enterthe desease, of complications that caused the death. Do not enter the mode of dying, such as cardad or respiratory arrest, shock, or heart fisher. Let only one cause on each section of the death o	4 Donatio	ion 5 Other Specify	y:	Ft L								
Physician Modical Xaminer  23a. Fart. Enterthe desease, of complications that caused the death. Do not enter the mode of dying, such as cardad or respiratory arrest, shock, or heart fisher. Let only one cause on each section of the death o	21. Signature o	of Fun ral Syrvice Lice	insee					1				
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July 9, 2009  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	5 Zya Cerrifier .	1 Certifying Physi	ician: To the best of m	y knowledge, o	death occurr	ed at the ti	me, date a	and place, a ath occurre	nd due to the ca d at the time. da	use(s) and te and place	manner as stat e, and due to t	ted. he cause(s)
July 9, 2009  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	ip   Grand		and manner stated.	allon and/C	voouydu					_		
30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	29b. Signature	re and title of certifier									- ,	nan, Day, I car)
Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		mes					U.U.IVI.E			July §	5, 2008	
						5	14:	MD 040	04			
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Registrar 1111 1 8 2009 Chause A. Addition	State 31. Date filed	(Month, Bay 1009	32. Registra	ir signatur	wed							

Registrar

State

31. Date filed (Month, Day,

JUL **1 8 200**9

DHMH 17 Rev 1/2001

AJIT KURUP M.D. 1835 UNIVERSITY BLVD E # 208 HYATTSVILLE, MARYLAND 20783

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 13, 2009 **Physician** Richard Franklin Ragsdale, Sr. July 1950 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Southern Maryland Hospital Center Prince George's Clinton Birthplace (State or Foreign Country) If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours Min 1**X** M 2□ F 579-16-8419 7. Maryland 86 1922 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 ☑ No MD Prince George's Temple Hills 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20748 USA 4316 Ranger Avenue Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1X1Yes 2 □ No If Yes, Give Year or Dates: 1943–45 1 Never Married 2X Married 1 □Yes 2X No Specify: Specify: White 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Special Assistant to Ambassador Nonprofit organization 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dick R Ragsdale Mabel Cecelia Sullivan ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Tracy A. Bautista/granddaughter 4316 Ranger Avenue Temple Hills, MD 20748 20b. Place of Disposition (Name of cemetery, crematory or other place)

Final Journey Crematory 07/15/09 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Woodbine, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens Golffigan Hothes Chemation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or es a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of perform 2 🗆 No 1 ☐Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? (Month, Day, Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Exprise must be required an angular or other traumatic event, it is Medical Exprise must be required as angue.

Physician

/Medical

Examiner

attending physician and for use as the burial-tran

signed by the a

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ours after death.

eral Director: After this certific filled in by the funeral director.

24 hours

Baltimore, Maryland 21215-0036

within 24 hor To the Fune completely f

State

29b. Signature and title of certifier

31. Date filed (Month

DHMH 17 Rev 1/2001

son who completed cause of death (Item 23a) (Type, Print)

29c. License number

OCD LIVE CEVIER WHATEN

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State
Registral MEND#3, perME, 7/16/09, DPS, MoCo Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month **Physician** 1704 mm Terry Marvin Schmitz July 14, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Montgomery Bethesda 8. Date of Birth (Month, Day, Year) 5. Social Security Number Sex 14 M 2 □ F 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 389-62-6967 53 Director May 30, 1956 Wisconsin Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir than "natural", or items 23a or 28a-f show the Wedical Examiner must be notified at Director 1 ☐ Yes 2 XNo Maryland Anne Arundel Laurel 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 246 Old Line Avenue 20724 Funeral United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 X Never Married 2 ☐ Married 1 □ Yes 2 No Specify δ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien. Important: If item 27 is marked other the any Injury or other traumatic event, ITel once. 12 None None 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Patrick Schmitz Elda Mae Beyer ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott Schmitz, Brother 246 Old Line Avenue, Laurel, MD 20724 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State July 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2009 Glen Burnie, Maryland 22. Name and Address of Facility
Thibadeau Mortuary Service, P.A. 21. Signature of Funeral Service Licensee Trum M01508 933 Gist Ave., LL, Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Intracranial Hemorrhage /Medical Due to (or as a consequence of): Examiner Subdural Hematoma Sequentially list conditions. Examiner Duie to (or as a consequence oil) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Head Injury with Complications attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? 2 ficate has been si 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 2 **X**No 1 ☐ Yes 2 📉 No : After this certific tuneral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐XYes 2∐No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury n 24 hours after death. • Funeral Director: A sletely filled in by the fa 1 ∐Yes 2 🛣 No 2 Accident 07/12/2009 10:00 PM Fall on stairs. 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 10017 Lorain Ave. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide ō Brother's Home 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. npletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month

Mauro Sarmiento, M.D.,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DENEUR

Baftimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

29c. License number D66895

8600 Old Georgetown Road, Bethesda, MD 20814

29d. Date signed (Month, Day, Year)

July 14, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 Month TITTY Physician 10:50 AM LARRY PHILLIP SLACK. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day,
April 5, FREDERICK FREDERICK MEMORIAL HOSPITAL 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 □ F 219-34-7519 69 1940 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1XYes 2 □ No Maryland Director Washington Keedysville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with 42 N. Main Street 21756 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐Yes 2X No Specify ş 3 Nidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, It. The Ite once. Elementary/Secondary (0-12) College (1-4or 5+) Metal Fabricator Manufacturing 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Robert E. Slack ္ပ Katherine R. Embrey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Keedysville, Maryland Justin S. Slack 42 N. Main Street 21756 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 07-20-2009 Frederick.\_Maryland Bast Stauffer Funeral Home, P.A. 21. Signature of Funeral daga Ma 7606 Old National Pike Boonsboro, MD 21713 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respinatory Failure **Physician** /Medical Due to (or a a consequence f) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Hospital or Attending Physician: The law requires that the death certificate be executed COPD and burial-tra Due to (or as a consequence of): physician Physician/Medical Immunodefi the attending | for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) 1 □Yes 2 □No ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation n 24 hours after death.

Reference Funeral Director: After the filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide

14-3

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a, Certifier

29b. Signature and title of certifier

PANDEY M.D. PRATIMA 31. Date filed (Month, Day, Year)

JUL 21

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

400 W. 7th Street

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

MDD 64910

29d. Date signed (Month, Day, Year)

Frederick, Maryland

-19-2009

To the Hosp within 24 ho To the Fune completely f

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

24509

Physician
/Medical
Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other thaumatic event, I'm Medical Examinar mast be notified at

Baltimore, Maryland 21215-0036

Physician // /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Physi	Part II. Other signific	cant conditions	contributing to do	ath but not reco	iting in the ::	indorlying saus- =	ivon in Da d		230 Did 4	abacco usa	oontribus-	to the cause of death?
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Fun	Medical	29a. Certifier (Check only 2 one)	2☐ Medical Exa	miner: On the ba	ısis of examinat	wiedge, deat tion and/or ir	th occurred at the nvestigation, in my	time, date a opinion, de	and place, and leath occurred	d due to the at the time,	cause(s) ar date and pla	id manner ace, and di	as stated. ue to the cause(s)
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State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** MARG ARET Year 1455 PM 2007 /Medical July 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY SHADY GROVE HOSPITAL ROCKVILLE 8. Date of Birth (Month, Day, Year) AUG - 23, 1920 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 T F Days Hours Min. PENNSYLVANIA 203-05-3640 88 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f shot any Injury or other traumatic event, Ithe Medical Examinating any Injury or other traumatic event, Ithe Medical Examinating and MONTGOMERY MD. Director ROCKVILLE Y☐Yes 2☐No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9701 VEIRS DRIVE 20850 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X1 No Š Specify. WHITE Specify: 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LEARNING CONSULTANT EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BERNARD C. WOLFE ALICE Z. HOUSEWORTH ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARYALICE STEVENSON-DAUGHTER- 9608 BYEFORDE RD., KENSINGTON, MD. 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 M Cremation 3 Removal from State METROPOLITAN CREMATORY-7/15/09-ALEXANDRIA, VA. 21. Signature of Funeral Service Acenses 22. Name and Address of Facility 2222-WISCONSIN AVE., NW HYSONG CO., INC. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. WASHINGTON, DC Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute minuse ? /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐Yes 2 ☑No 2 1 No Division of Vital 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ■ PR/Outpatient 3 ☐ DOA မ 27. Man of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Dax 8207 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROCKVILLE VIPUL Kella

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

MERICAL

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 Year 11, **Physician** July 1:25p<sup>M</sup> Margaret Louise Stancliff /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner La Plata

Vaar | If Under 24 Hrs. Charles Charles County Nursing& Rehabilitation Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days Min. 1 □ M 2 🙀 F 87 6-25-1922 Franklin,P.A. Director 178-14-8801 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State ms 23a or 28a-f show 1√2 Yes 2 □ No Director La Plata Charles M.D. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 20646 United States 241 Williamsburg Circle Funeral death 1 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? th and Mental Hygiene. 7 is marked other than "natural", or items traumatic event, the Medical Examinating permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Event nuonce. 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 21X No Specify: Specify: White \$ 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Private Cosmetology Instructor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Isabel Mason Lawrence Strawbridge 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. Box 356 Port Tobacco, MD 20677 Richard H. Stancliff Jr. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery: 7-16-2009 | Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Licenses 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Road Brentwood MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mins **Physician** Myocardial Infarction /Medical Due to (or as a consequence of): Examiner Years Hypertension Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 1 □Yes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Coronary arterial disease, diabetes mellitus, Completed 24b. Were autopsy findings available prior to completion of cause of death? peripheral vascular disease 24a. Was an s certificate has the lirector, page 2 s 1 □Yes 2 No 2 No 1 ☐ Yes this certific al director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 412 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death After Injury 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: d in by the f 6 ☐Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical To the Hosp within 24 ho To the Fund completely f

10

State Registrar

Ravinder K Sindhwani, MD 31. Date filed (Month, Day, Year) JUL 1 6 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



29c. License number

5 Garrett Avenue La Plata, MD 20646

D0061614

29d. Date signed (Month, Day, Year)

7/14/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of N	iaryian		artment of I rtificate of		na Me	, ,	Iene eg. No. 🤈 🦳 :	nia.	01.510
	Physic	00	1. Decedent's Name (First, Midd	fle, Last)					2	. Date of Deat Month		/ear	3. Time of Death
	/Medi		Dorothy Regi	na Saxty					$J_1$	uly 14	, 2009	i e ai	5:10 P M
	Examir	ner	4a. Facility Name (If not institution	on, give street and number	r)		4b. City, Town, or Location of Death				4c. County of Death		
4			Bowie Health				Воч				Prince George's		
	Funeral Director		5. Social Security Number 579–26–0226	6. Sex 7. A 1 ☐ M 2 ဩ F	ige (In yrs 83	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min.	Date of Birth (Month, Day, one 10,	Year) 1926 Wa	9. Birthp Cour ashi	place (State or Foreign ntry) ngton, DC
	and		Usual Residence of Decedent  10a. State 10b. County	V	10c. Cit	y, Town or Lo	cation					1	0d. Inside City Limits
	f sho	ō		e George's	100.0.	Lanhar						Γ.	12X Yes 2 □ No
	the N	rect	10e. Street and Number				10f. Zip Code			1	0g. Citizen of Wh	at Cour	
	23a or	Funeral Director	5710 Misty Dri	.ve				20706			US		u y :
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, The Modical Exerciting roughly and once.	by Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Mai 3 🕅 Widowed 4 ☐ Divorced	If Yes Give	? (No		Vas Decedent of H fYes, specify Cub □Yes 2∑No	dispanic Origin an, Mexican, P Specify:	n? (Specif Puerto Ric	y Yes or No- can, etc.)	14. Race Black,	White,	etc.
5-(	72 h 'natu dical	ete	15. Deceder	nt's Education est grade completed)		16a. Deced	lent's Usual Occup	ation	f working		16b. Kind of Busi	ness/Ind	dustry
2121	within liene. • than	Completed by	Elementary/Secondary (0-12)	College (1-4or	5+)	life. D	kind of work done OO NOT use retire Homemake		worning		Own	Home	2
b	filed Il Hyg othe	BeC	17. Father's Name (First, Middle,	, Last)					Name (F	First, Middle, N	faiden Surname)		
Maryland	2 should be filed w and Mental Hygie is marked other ti raumatic event, I'll	10 E	John Weber					Mar	ie S	chmitt			
ar	2 sho rand is ma	ľ	19a. Informant's Name/Relations	ship (Type. Print)		19b. Mailin	g Address (Street	and Number o	or Rural F	Route Number,	City or Town, S	tate, Zip	Code)
≥, ≥	1 and 2 Health tem 27 is		Susan Simpson	- Daughter			Ormsby		Cro	fton, N	<b>1</b>	4	
ore	ges 1 t of H If itel		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 ☐ Removal from State	20b. P	Place of Dispos emetery, crem	sition (Name of natory or other plac	ce)	Date	9 2	20c. Location - C	ty or To	wn, State
Ë	trmen tant: jury		4 Donation 5 DOther (5		Gate	e of He	eaven Cem	etery 7,	/17/2	2009   S	ilver Sp	prin	g, MD
Baltimore,	permit. Pages 'Department of H Important: If ite any Injury or of		21. Signature of Funeral Service	Licensee  RAM Rogens			Name and Addre		Home	. P.A.			nore Ave. e, MD 20781
			23a. Part 1. Enter the disease, o shock, or heart failure. List	r complications that cause	d the death								Approximate
	Physician		Immediate Cause (Final disease or condition	•		ons fro	om Colect	omv an	d i1	eostom	J		Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as								-	<del></del>
	Examiner		Sequentially list conditions	b			icile col	itis					
	led isit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	uence of):							
•	xecur al-tran	xan	that initiated events resulting in death) Last	c Due to (or as	a consequ	uence of):				· <del></del>		-	
68760,	tificate be executed g physician and as the burial-transit	ia E		2 20 (0)	a concoqu	301100 017.							
687	ificate g phy: as the	edical		d			_						
			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Date	of delive	ery
	0 0 0	Physician/N	in the past 12 months? 1 □ Yes 2 ♣ No	1 ☐ Live birth 4 ☐ Pregnant			Ectopic pregnand  Other <i>(specify)</i> _	у			Monti		Day Year
P.O.	that the de ned by the a detached t	hys	9 ☐ Unknown	9 ☐ Unknown									
Vital Records,	The law requires that the ate has been signed by the bage 2 should be detache	ē	Part II. Other significant condition Atrial fibr		out not resu	ılting in the un	derlying cause giv	en in Part I.					e cause of death? ably 4 🗆 Unknown
Š	v requ	Completed							-				
Be	The law cate has page 2 s	dm							- [	24a. Was an autopsy perform	/ pri		osy findings available npletion of cause of
			25. Was case referred to medica				_			1 □Yes 2	12 No 1 E		2 □No
>	Physician: this certific al director,	o Be	examiner?	Hospital:	iont 2 Kill	ER/Outpatient	Oth	er.		heck only one	<u> </u>		
	g Phy erthi eral c	ř	27. Manner of Death	28a. Date of Ini	urv	28b. Time of	28c. Injur Worl				nce 6 Other	(Specify	/)
ö	Attending r death. sctor: Afte by the fune	atio	1 XNatural 5 Pendin 2 Accident investi		ay, rear)	Injury		<br Yes 2 □No					
S	i gige	Certification: To	3 ☐ Suicide 6 ☐ Could determ	not be nined 28e. Place of In building, e	ury - At hou tc. <i>(Specify</i>	me, farm, stre	et, factory, office		28f.	Location (Str City or Town,	eet and Number State)	or Rura	Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled		29a. Certifier 1 Certifyir (Check only 2 Medical	ng Physician: To the best Examiner: On the basis	of my know	wledge, death	occurred at the timestigation in my	me, date and p	olace, and	d due to the ca	use(s) and mani	ner as st	tated.
	the I	Medical	One)	and manner s	ated.								
	5 × 5 ×		29b. Signature and fitte of certifie	1/1/			29c. Licens			29	d. Date signed ( 7 / 15 / 20		Jay, Year)
	6	-	- OKYU	May			D43	7) I			1/13/20	J J	
	(4)		30. Name and address of person Dr. Ikechi Fre				rint) Delt Rd,	Sta II-	.15	Collage	a Park	MD '	20740
	Sta	e l					JETC MU,	J.E 0-	17,	OUTTER	L IAIK,	-11/ 4	207-10
	Registr:		31. Date filed (Month Day Year)	men 1.	rar's signat								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Hattie Spencer 4, 2009 9:35 AM /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico Salisbury Rehabilitation + Nursing Ctr lisbur 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) 12/17/1920 If Under 24 Hrs. **Funeral** Hours Days Months 1 □ M 2 😿 F 88 228-18-2098 Virginia Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Wedical Examiner must be notified at 1☐Yes 2☐No Director Maryland Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 200 Civic Ave. 21804 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No þ Specify: white 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) domestic Housewife 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Amanda Wallace Elisha C. Pruitt ဂ္ Pages 1 and 2 should or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1006 Heron Ct., Salisbury, MD 21804 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health au
Important: If Item 27 is
any injury or other trau Constance Lewes/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/17/09 Shad Point Cemetery Shad Point, MD 21. Signature of Funeral Service Licen 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) lau /Medical Due to (or as a prinsequence of): **Examiner** Sequentially list conditions, if any leading to in models cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit luco Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ۵ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

P.O. Box 68760, Records, of Vital Attending Physician: Division ō

Maryland 21215-0036

Baltimore,

Spence 6

State Registrar

31. Date filed (Month, Day, Year) **JUL 16** 

29b. Signature and title of certifier

Name and address of

and manner stated

29d. Date signed (Month, Day, Year)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month OG **Physician** 01:05 07 0 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Mandrin Hospice House Harwood Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. Months 1 □ M 2 🗹 F PA 76 160-28-8357 4/10/1933 Director Usual Residence of Decedent 10d. Inside City Limits 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a. State r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 🏋 No Anne Arundel Shady Side Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20764 1223 Hawthorne St. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give 11 Marital Status White Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify δ Year or Dates: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withit Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainment. filed within College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hilda Nick Tavernaris 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Shady Side, MD 20764 1223 Hawthorne St. Spouse William T. Swager Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 7/14/2009 Galesville, MD Quaker Burial Ground 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hardesty Funeral Home, P.A. Annapolis, MD 21401 12 Ridgely Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760 attending physician Physician/Medical the as IF FEMALE: for use yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Yes P.0. the 9 Unknown detached 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy performed? The certificate 1 □Yes 2 □No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica MANDRIN funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 1 C E Hospital: 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b Time of 28d. Describe how injury occurred HUSE 27. Manner of Death 28c. Injury at Work? Injury 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated within 2 To the F 29c. License number 29b. Signature and title of certifie

State Registrar

31. Date filed (Month, Day, Year) **JUL 15** 

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ame and address of person wh

32. Registrar's Signature

av e of death (Item 23a) (Type, Print)

EFENSE HIGHWAY ANNAPOLISM DILYU

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Month July 14, 2009 12:30AM Maryelizabeth Smith 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 2529 Avalon Place Hvattsville Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Days 1 ☐ M 2X F 098-12-3405 87 Jan 18, 1922 New York Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Prince George's Hyattsville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2529 Avalon Place 20783 USA 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Smith Emma Rittinger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul W. Smith/son 2529 Avalon Place Hyattsville, MD 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 XCremation 3 Removal from State Final Journey Crematory 07/15/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service License Going Modes Chellation Service P.O. Box 784 Heverly I MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the mease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1 month disease or condition resulting in death) Cerebrovascular Accident Due to (or as a consequence of) Atrial Fibrillation 10 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month 5 ☐ Other (specify) 9 Unknown 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 ANo 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 24 No 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Inc. M. 2018.

**Physician** 

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

Be

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**Funeral** 

Director

ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Examine attending physician and for use as the burial-tran Physician/Medical ed by the detached Completed by nas certificate Be Certification: To After

the Hospital or Attending Physician: The law requires that the death certificate be executed I Director: d in by the f within 24 hours aft

To the Funeral Di

completely filled in

Division of Vital Records, P.O. Box 68760,

Jennie Go, M.D. State Registrar

5 ☐ Pending investigation

6 ☐ Could not be

determined

25. Was case referred to medical examiner?

29b. Signature and title of certifier

1 Yes 2 No

27. Manner of Death

1 XNatural

2 Accident

3 ☐ Suicide

29a. Certifier

Medical

4 Homicide

1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

D64928

1 ☐Yes 2 ☐No

29d. Date signed (Month, Day, Year) 29c. License number

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

July 13, 2009

26. Place of Death (Check only one)

completed cause of death (Item 23a) (Type, Print) 30. Name and address of person wh

10810 Connecticut Ave. Kensington, MD 20895

Registrar's Signature resul

28a. Date of Injury (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) JULY 13 2009 7:15 P M **Physician** YARA MAHER TOTAH /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MONTGOMERY NATIONAL INSTITUTES OF HEALTH BETHESDA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 2, 1987 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Israel 1 □ M 2 🖺 F Months Davs Hours 22 624-02-2622 Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'le Medical Exprinimer mat Le notified at any injury or other traumatic event, I'le Medical Exprinimer mat Le notified at 10d. Inside City Limits 10c. City, Town or Location 10a, State 10h County 1 ☐ Yes 2 No Director California San Mateo San Bruno 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 420 Madison Avenue 94066 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 MZNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 🔀 No Specify. ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Education Student 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rula Hanna Rabah Maher Issa Totah ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 420 Madison Avenue, San Bruno, CA 94066 Maher Issa Totah/Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition July 21 injury or 1X Burial 2 ☐ Cremation 3 X Removal from State Ramallah City Cemetery Ramallah, Israel 2009 4 ☐ Donation 5 ☐ Other (Specify) 22, Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd. W., Silver 21. Signature of Funeral Service Licensee any in Inc. Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Zone Lymphoma 9/2008-7/15/09 Gray disease or condition resulting in death) /Medical Due to v r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician; The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-trar that initiated even Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 □ Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 ANo After this certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes director, 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No neral Director; A investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D. O. 1939 ME an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 CENTER DRIVE, BETHESDA, MARYLAND 20892 SARAH J. SINCLAIR

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Monta

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Elaine Talbert July 4:35 A M Genevieve 2009 18 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Washington Fahrney Keedy Home and Village Boonsboro Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 17, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours 1 ☐ M 2 🛛 F 218-38-1044 86 1923 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 X No Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21713 8507 Mapleville Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2X No Specify. 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nursing Home Cook 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Brandenburg Pear1 Hooper Charles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Boonsboro, Maryland 21713 Robert E. Talbert Sr. / Scn 21433 Greenbrier Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 07-21-2009 Boonsboro, Maryland Mt. Zion Cemetery 21. Signature of Funeral Service Licenses Bast Stauffer Funeral Home, P.A. 7606 Old National Pike Boonsboro, MD 21713 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) amagest the Hear Due to as a consequence of): Rev hvario Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pertusily Due to (or as a consequence of): bejec IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide

P.O. Box 68760, တ် Record Division of Vital

the Hospital or Attending Physician: To the Hosp within 24 hou To the Funer completely fil

06H-3

Physician/Medical 2 Completed Be Certification: To Medical

Examine

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

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permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examples and any injury or other traumatic event, the Medical Examples.

**Physician** 

/Medical

Examiner

sician and burial-transit

cate has been signed by the attending physician page 2 should be detached for use as the buria

this certificate

24 hours after death.
Funeral Director: After this certific etely filled in by the funeral director, I

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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death with the Maryland

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

21740

29b. Signature and title of certifier

29c. License number 1152323 29d. Date signed (Month, Day, Year) 3-2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1126 Opal Court Khalid Waseem, MD Hagerstown, Maryland

and manner stated.

31. Date filed (Month, Dev.

4 Homicide

29a. Certifier

Registrar's Signature



State

Registrar

			For 1 - State Registrar	State of Maryland	-	rtment of H <i>tificate of L</i>			0 0 0	9 24518	
	Physici		1. Decedent's Name (First, Middle, Last) Abraham Thomas					2. Date of Death July 13		3. Time of Death 12:08 а м	
1	/Medic Examin		4a. Facility Name (If not institution, give street 402 Dias Dr.	eet and number)		4b. City, Town, or Fort Was			4c. County of I	Death	
	Funeral Director		5. Social Security Number 6. Sex 1X N	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 22	Yea <i>r</i> ) 942 So	Birthplace (State or Foreign Country) Outh Carolina	
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, T	own or Loc	ation				10d. Inside City Limits	
	Ba-f sh	ector	MD PG			Fort Was	hington			1 X Yes 2 □ No	
	h with th	al Dire	402 Dias Dr.			10f. Zip Code 20744		10	g. Citizen of Wha	t Country?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, It. If Solical Examiliar must be inclined at once.	by Funeral Director	11. Marital Status  1  Never Married  Married  3  Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1Yes 2 \( \) No If Yes, Give Year or Dates:	1	Vas Decedent of Hi Yes, specify Cubar □Yes 🎢 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		American Indian, Vhite, etc. Black	
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212	d withir /giene. <b>er than</b>	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)		Painter		E .	Private		
and	d be file ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last)  Kyer Thomas				18. Mother's Nam Blondell	e (First, Middle, M Gl	laiden Surname) L <b>i</b> nyard		
Mary	nd 2 shou alth and M 27 is mar r traumati	-	19a. Informant's Name/Relationship (Type Bethann P Thomas/ W.			g Address (Street a				ate, Zip Code)	
Baltimore, Maryland	Pages 1 ar		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Ren 4 □ Donation 5 □ Other (Specify)	cem	eterv crem	sition (Name of latory or other place Ln Cemete	a) '	i	Oc. Location - Cit		
Balti	permit. Departm Importa any Inju		21. Signature of Funeral Service Licen	1	10	Name and Addres	s of FacilityRon; leport Li	ald Taylo n. White	or II FH Plains,	MD 20695	
			23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death. I cause on each line.	Do not ente	er the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	METASTATIC  Due to (or as a consequent		2061NIE	CANCE	R		Onderand Dodan	
	Examiner	Ŀ	Sequentially list conditions, b.	Due to fur as a consequent							
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58760,	ficate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a consequen	ce of):						
289	ertificate ing phy as the	Medical	IF FEMALE:								
.O. Box	the death ce y the attend iched for use	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	eath 3	Ectopic pregnancy Other (specify)	1		23d. Date of Month		
rds, P.	quires that in signed build be deta	by	Part II. Other significant conditions contri	buting to death but not resultir	ng in the un	derlying cause give	en in Part I.		. /	ite to the cause of death?	
al Records,	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed						24a. Was ar autops perform 1 🗆 Yes 2	/ prio	re autopsy findings available or to completion of cause of th?  Yes 2 Mo	
Z Z	ysician s certif director	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	pital: 1 ☐ Inpatient 2 ☐ ER	I/Outnatien	t 3 DOA Othe	· · ·	th (Check only one		(Spacify)	
n ol	ing Ph After th uneral	on: T	27. Many r of Death 1 ☑ Natural 5 ☐ Pending		b. Time of Injury	28c. Injury Work	at ?	28d. Describe ho		(Specify)	
Division of Vital	or Attend after death Director: / in by the f	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre		∕es 2 □No	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	e Hospita 124 hours e Funeral fetely filled	Medical Ce	29a. Certifier (Check only one) 11 Certifying Physic 2 Medical Examine	ian: To the best of my knowle c: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the time vestigation, in my op	ne, date and place pinion, death occu	, and due to the carred at the time, da	ause(s) and manrate and place, and	ner as stated. If due to the cause(s)	
	To the complete	Me	29b. Signature and title of certifier			29c. License		29	/	Month, Day, Year)	
	4		30 Name and distance of necessary who com		20\ (Tim= *		16619		VELLY.	14, 2009	
	6)		30. Name and address of person who com	ES 4041	POLOS	DERMILL A	QD. CAL	VERTON	MD.	20705	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	9				/		

amend #20b&c Please Typesy3Printin Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 13, 2009 11:45 A Todd Mary E. Ju1y /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Months Days Hours Director May 29, 1938 577-68-5965 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show ms 23a or 28a-f s must be rutified Director 1XYes 2 □ No Prince George Hyattsville Maryland | the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4922 Lasalle Road 20782 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) r than "natural", or items 14. Race - American Indian, 11, Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Black Specify: δ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Private Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be of Health and Mental H item 27 is marked oth r other traumatic even Charlie Davis Mary E. Griffin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2555 Pomeroy Rd. SE Washington, DC Constance M. Stevens/ Daughter 20b. Place of Disposition (Name of RESSCIPECT 1 of Processing 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ott July 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Clinton, Maryland 4 Donation 5 Other (Specify) Mt. Olivet 24, 2009 Washington, DC 21. Sanature of Funeral Service Live need 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd. NE Washington, DC 20019 23a. Part 1 Enter the disease, or complications that caused the death. Do Not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Se 15Si **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Attending Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) P.O. Box 68760. cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical 23c. if yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 🖾 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hen MUNI autopsy 1 □Yes 2 ₺No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To nours after death.

neral Director: After this

y filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 PNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ò Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) To the within 2 and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 07-15-09 00060100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A HM PO BLVD East 3 University MO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State garle 2009 Registrar

Please Type or Print in Black Indelible link. 7538469 All Copies Are Legible.

Amend Item 25 per ME 15893. 7538469 All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician 2009 07 0700 EDITH JUNE TAYLOR /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FROSTBURG VILLAGE NURSING CENTER FROSTBURG ALLEGANY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 1 MARYLAND Director 26 1924 220-16-7102 84 Usual Residence of Decedent 10d, Inside City Limits show 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Infoical Examinatings to use the resiliation MD ALLEGANY LAVALE 1 ☐ Yes 2 XNo Director 10g. Citizen of What Country? 10f. Zip Code 21502 10e. Street and Number U.S.A. 101 MARY COURT 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 No Specify à 3 Widowed 4 Divorced WHITE Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CELANESE CONING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LEWIS MCKENZIE IVA BITTNER MCKENZIE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health a CHARLES W. TAYLOR HUSBAND 101 MARY COURT LAVALE, MD 21502 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of IImportant: If ite
any injury or otl
once. 1 ■ Burial 2 Cremation 3 Removal from State 07-27-2009 FROSTBURG, MD FROSTBURG MEM PARK 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOWERS FUNERAL HOME, P.A. 4190 -moo547 2013 60 W. MAIN ST., FROSTBURG, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition convinan Dr zease **Physician** resulting in death) /Medical Due to (or as a conseque ce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-tran Due to (or as a consequence of) Box 68760. physician certificate be Physician/Medical the for use as attending IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day 5 Other (specify) ed by the a detached f Ö 9 Unknown 9 Unknown signed by the ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ → Repown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Norsing Home 5 Residence 6 Other (Specify) XXYes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division Natural 5 Pending G0>8,746 PARKING 1 □Yes 2 No death. investigation 609 s after death. filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Pla e of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide PARKING MENORIAL To the Hospital within 24 hours a To the Funeral C completely filled Hospital 29a. Certifier Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 Broad way 32. Registrar's Signature

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Jesus M. Ion 31. Date filed (Month, Day, Year)

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**ORIGINAL** 

MI) 21532

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Sr. 0535 Donald Teets 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 9. Birtholace (State or Foreign Country) MD WMHS-Memorial Campus mberl If Under 24 Hrs Date of Birth (Month, Day, Year) Nov 11, 1938 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 **Funeral** Months Days 1 → M 2 □ F 219-34-6308 70 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a marked other traumatic event, if a marked event e 10d. Inside City Limits 10a. State 10b. Count 10c. City, Town or Location MD Allegany Oldtown 1 ☐ Yes 2 ☐ No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21555 15502 Levi Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No 14. Race - American Indian. Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 →No If Yes, Give Year or Dates: Specify. ģ 3 Widowed 4 Divorced white Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) City of Cumberland laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Georgia Howsare Teets Chancy Teets မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
15604 Levi Road Oldtown MD 21555 19a. Informant's Name/Relationship (Type. Print) Diana Crabtree daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Scarpelli Funeral Home, P.A. Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Kremation 3 ☐ Removal from State 7/28/2009 MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DOGN disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 3 Probably 4 Unknown 2 🗌 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 -NO 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this after death.
I Director: After this d in by the funeral di 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) determined 4 Homicide To the Hospital or within 24 hours aft To the Funeral DI completely filled in 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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State Registrar 30. Name and add

31. Date filed (Month, Day, Year)

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person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** BETTY LEE TRAVERS 7/23/2009 2:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner CHESAPEAKE WOODS CENTER CAMBRIDGE DORCHESTER Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. Director 218-12-1753 84 11/17/1924 MARYLAND Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 1X Yes 2 No Directo MARYLAND DORCHESTER CAMBRIDGE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ō 23a 708 MARYLAND AVE Funeral 21613 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No þ Specify Specify. 3 Widowed 4 Divorced WHITE "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RESTAURANT OWNER FOOD SERVICE 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES IRVING HURLEY 2 ADELL S. LATHAM 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a DIANE A. FITZHUGH / DAUGHTER 2905 CENTRAL RD., CAMBRIDGE, MD 21613 item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/28/2009 4 ☐ Donation 5 ☐ Other (Specify) EASTERN SHORE VETERANS CEMETERY HURLOCK, MD 21. Signature of Funeral Ser 22. Name and Address of Facility CURRAN-BROMWELL FUNERAL HOME, P.A., 308 HIGH ST., CAMBRIDGE, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 400 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. if yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Empheseng Completed HEART Failuse 2 🗌 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? reertificate has birector, page 2 s 24a, Was an autopsy performed? Yes 2 100 sepital or Attending Physician: Theoris after death.
Ineral Director: After this certificate y filled in by the funeral director, pa Anemia Osteo porosis 1 □ Yes 2 **AN** 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 | Yes 2 | 1 | 1 | 1 | 1 | 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Aatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Hospital 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar 29b. Signature and title of certifier

30. Name and address of person who

31. Date filed (Month,

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Year)

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completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 📙 🖯 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician  $\operatorname{JULY}^{\mathsf{Month}}$  $1\overline{1}$ 2009 5:25 p PEARL UZZELL /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges Prince Georges Hospital Cheverly If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Apr. 5, Birthplace (State or Foreign Country)
 NC 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1935 Months Days Hours 1 □ M 2 🛂 F Yrs 74 579-46-4667 Apr. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Worle 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "netural", or iteme 23a or 28e-f ehov the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Prince Georges Capitol Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4704 Heath St. 20743 USA Funeral 13. Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: ģ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Teacher DC Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: if Itam 27 is marked oth any injury or other treumatic event 9DR. Be 2 Benjamin E. Uzzell Mary Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty U. Gross - Sister 4706 Heath St. Capitol Heights, MD. 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial 7-16-2009 Landover, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Marshall's Funeral Home of Maryland 4308 Suitland Rd. Suitland, Md. 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) nevo Scleyotic **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) sician and burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): ng physician a Box 68760, Completed by Physician/Medical attending a IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury Certification: 28d. Describe how injury occurred Division 5 Pending investigation 1 XNatural 1 ☐ Yes Director: 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C completely filled 1 Z Certifying Physician: To the bast of my knowledge ideath occurred at the time, date and place and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 1109 00060100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A cfm in a A Grupo Universily BLV0 Sagl Silven Spring 31. Date filed (Month, Day, Year) 32. Registrar's Signaturé State JUL 1 6 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene 24524 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Jul 2009 **Physician** 9 Mamie T. . Washington 7:36 p<sup>M</sup> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Hospital e George's

9. Birthplace (State or Foreign Country) Cheverly
If Under 1 Year If Under 24 Hrs. Prince 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min 1□M 2₩F Yrs 1940 North Carolina 579-52-5345 10 Sep Director 68 Usual Residence of Decedent death with the Maryland 10d. toside City Limits 10c. City, Town or Location 10a. State 10b. County Item 27 is marked other than "naturel", or Items 23s or 28s-1 show other traumatic event, the Medical Examinar must be notified at 1⊠Yes 2 No DC Director Washington 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 4 Girard Street, N.E. 20002 USA Funerai Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Amed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after inner of Health and Mental Hygiene. ont: If Item 27 Ie marked other than "naturel", or Ite 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) Administrative Specialist Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Thad Knight <u>Helena Hilliard</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20019 19a. Informant's Name/Relationship (Type, Print) Charles Washington/husband 3400 Minnesota Avenue, SE #202, Washington, DC 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: If Ite eny injury or ot once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Ft Lincoln Cemetery | Jul 20 2009 Brentwood, MD 2). Signature of Fureral Service Licensee 22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Road, Landover, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** TATAL /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a consequence of). Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as t signed by the attending I be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown should t Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy After this certificate ha funeral director, page performed 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitat: 2 ER/Outpatient 3 DOA 1 Tes 2 No 1 Inpatient 2 27. Manner of Death 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation d in by the f 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature a address of person who completed cause of death (Item 23a) (Type, I HOSPITAL 3001 AMIE WOOD HALL 31. Date filed (Month, Day, Year)
JUL 1 6 2009 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Khim Huot Yang July 14, 2009 8:10 pM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 XF Director 217-96-7518 78 Cambodia Feb. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Buring the state of the state of the than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It is Marited Examines must be notified as Maryland Montgomery North Potomac 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Seurat Court 20878 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Mo Specify: If Yes, Give Year or Dates: Specify: Asian ģ 3 Midowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ngourn Huot Rom Huot ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Khun Eam Chhay/Son 9902 Hellingly Place, Gaithersburg, MD 20886 20b. Place of Disposition (Name of cemetery, crematory or other place)
Stevensville Cemetery 20a. Method of Disposition 20c. Location - City or Town, State July 19 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Stevensville, Maryland 21. Signature of Funeral Service Licenses 22 Name and Address of Eacility Francis J. Collins Funeral Home Inc. cere 500 University Blvd. W., Silver Spring, MD 20901 23a. Part f. Enter the insease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit Physician/Medical Box IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) Ö 9 Unknown signed by t ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 ☐Yes 2 PNo 1 Yes Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ၉ Nopatient 2 ER/Outpatient 3 DOA of this Jang, 14, Division of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: d in by the t 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier Ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 30. Name and address of person who completed cause of death (them 23a) (Type, Print)
Gita Bakhshi, MD 9406 Old Georgetown Road, Bethesda, MD 20814 31. Date filed (Month, Day, Year) State 32. Registrar's Signature JUL backer Registrar Census

15

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2009 06, 2255 **EDITH** JULY YOUNG Ε. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE HOSPITAL CHEVERLY PRINCE GEORGE If Under 1 Year Months Days If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 ☐ M 2 🗓 F Yrs. MARYLAND Director 213-40-8493 74 02-20-1935 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits works Y Yes 2 No MD PRINCE GEORGE KETTERING Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11904 WIMBLETON STREET 20774 U.S.A. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Yes 2X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2\No Specify Specify: BLACK þ 3 Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) if Health and Mental Hygiene. GOVERNMENT 3yrs CIVIL SERVICE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be SUSIE DYSON JOHN HILL ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FREDRICK TYLER/FRIEND 11904 WIMBLETON STREET KETTERING, MD 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of P Important: If ite any injury or ot once. 1 ∑Burial 2 □ Cremation 3 □ Removal from State 7-28-2009 4 ☐Donation 5 ☐ Other (Specify) ARLINGTON CEMETERY ARLINGTON, VA permit. 22. Name and Address of Facility JB JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition FATAL CARDIAC ARRYTHMIA **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner CARDIAC ARREST Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760 attending physicien Completed by Physiclan/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2☐Fetal dea 4☐Pregnant at time of death 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown detached o. 9 Unknown à <u>م</u> 23e. Did tobacco use contribute to the cause of death? Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, g 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 🛣 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No 1 Yes 2 XNo 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 🕅 EP/Outpatient 3 ☐ DOA Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) r 1 ☐ Yes 2 ₹☐ No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death 2 Accident 24 hours after deat Funeral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certiffs 29c. License number D6536 2009 Oa 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 MEHDI SATTARIAN, MD 3001 HOSPITAL DRIVE CHEVERLY, MD 20785 32. Register's Sig State Registrar

■ Baltimore Maryland 21215-0036

Division of Vital Records. P.O. Box 68760.

		For Amend Items 25 at 2 Pf Mery 29/20/20/20		tale of the	egible.			
			ertificate of Death	Reg. No.	2009 21527			
Physici	ian	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day	3. Time of Death			
/Medi		Elmer Dale Allgood		July 15, 20				
Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat		County of Death			
Funeral	7	Wilson Health Care Center   5. Social Security Number   6. Sex   7. Age (In yrs. last birthda		8. Date of Birth	9. Birthplace (State or Foreign			
Director		447-28-7423 1⊠ M 2□ F 78 Yrs.	Months Days Hours Min.	(Month, Day, Year) May 26, 193	Country) Oklahoma			
put w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits			
/aryla f sho	5		Location		1 ☐ Yes 2 🕅 No			
the N	Director	Maryland Montgomery Damascus  10e. Street and Number	10f, Zip Code	10g. Citiz	en of What Country?			
id Z 12 13-0030 filed within 72 hours after death with the Maryland Hygene. other than "natural", or items 23a or 28a-f show ent, the Medical Examinar must be profitted at		11005 Locust Drive	20872	USA				
13-UU30 172 hours after death w "natural", or items 23a odical Examin or must b	Funeral		3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- 1-	Race - American Indian,     Black, White, etc.			
s after	by F.	1 ☐ Never Married 2 🕅 Married 1 📆 Yes 2 ☐ No	1 ☐ Yes 2 X No Specify:		Specific			
hour tural	ed b	3 ☐ Widowed 4 ☐ Divorced   If es, Give Kor. & Viet ↓  15. Decedent's Education   16a. De	cedent's Usual Occupation		White  Ind of Business/Industry			
in 72	plet	(Specify only highest grade completed) (Gi	ve kind of work done during most of wor b. DO NOT use retired)	rking	d of Business/madstry			
d with giene	Completed	12 Polic	e Officer	Law H	Enforcement			
De file tal Hy d oth	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Nar	me (First, Middle, Maiden S	Gurname)			
Tal ylailla 2 1.2 2 should be filed within 1 and Mental Hygiene. Is marked other than aumatic event, Inc. M.	မ	Charles Allgood		lae Hardesty				
			illing Address (Street and Number or Re	•				
s 1 and 2 of Health item 27 other tra			5 Locust Drive, Da  position (Name of rematory or other place)		tland 20872 cation - City or Town, State			
permit. Pages 1 Department of P Important: If ite any Injury or ot		TES Bullar 2 Diefilation 3 Di Removal from State	i					
permit. F Departm Importar any Injur		Durem me	thodist Cemetery 7 22. Name and Address of Facility Mo		liams Funeral Home			
Depart Impo			26401 Ridge Road,					
		2 3. Fart 1. Enter 11. disease, or complications that cause the death. Do not a shock, or heal failure. List only one cause on each lin.	enter the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between			
Physician		Immediate Cause (Final discuss or condition Adult Vaile	re to Think		Inmilia			
/Medical Examiner		Due to (or as a consequence of):			12/24			
	er	Sequentially list conditions, if any, leading to immediate  b. Due to (*r as a construence of):			2/07			
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ite be executed sysician and he burial-transit		resulting in death) Last  Due to (or as a consequence of):		<del>/ / / // // //</del>	EVAMINER			
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The law requires that the death certificate are has been signed by the attending phyloage 2 should be detached for use as the	Physician/Medi	IF FEMALE:	CERNFION					
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at the de	ysic	1 Yes 2 No 4 Pregnant at time of death 9 Unknown	5 ☐ Other (specify)					
s that	by Pl	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco us	se contribute to the cause of death?			
w requires is been sign should be	ed b	Hart II. Other significant conditions contributing to death but not resulting in the	) dergune	1 ☐ Yes 2 🗷	No 3 Probably 4 Unknown			
e law rec has bee	plet	disarter. Typestense	n	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of			
The cate ha	Completed	Appene pidernea Chatmicks	ne enopathy	performed?	death? 1 ☐ Yes 2 ☐ No			
Iclan: Th certificate ector, pag	Be	25. Was case referred to medical examiner?		ath (Check only one)				
ding Physician, h. After this certifit funeral director,	.T	1 Yes 2 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat  27. Manner of Death 28a. Date of Injury 28b. Time		fome 5 ☐ Residence 6 28d. Describe how injury				
nding th. Afte	tion	TEINatural 5 □ Pending (Month, Day, Year) Injury 2 X Accident investigation 12/2007 Unknown	/ Work?		ll in bath tub.			
Atter ar dea ector by the	ifica	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, so building, etc. (Specify)	WH -	ļ. <u> </u>	Number or Bural Route Number, 11005 Locust Drive			
saffe al Dir	Certification:	Home (Specify)		Damascus, MI				
	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	e, and due to the cause(s) aurred at the time, date and p	and manner as stated. place, and due to the cause(s)			
Fo the vithin Fo the somple		29b. Signature and title of certifier	29c. License number	29d. Date	signed (Month, Day, Year)			
		ARabicit Derrecht and	04-115	Les	15 2009			
		30. Name and address of person who completed cause of death (Item 23a) (Typ.  IV. RUBZKT 3/RSC(HBACH, DLA)	e, Print) 20/RUSSE	LL A VENUE	20877			
Stat		31. Date filed Manth, Par Year 199 32. Registrar's Signature	Ked CORELLY CK S	scir wir was	1001			
Registra	egistrar 30L 10 2000 personal production in the second production in th							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #8 per Fh & 894 8/10/09 TT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Dea <sup>Day</sup> 2009 Physician Year MARY ABOAGYE July 7 20:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Hospital Rockville Montgomery 8. Date of Birth 2/15/40. Birthplace (State or Foreign (Month, Day, Vear) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F 69 Director unknown Ghana Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show an injury or other traumatic event, the Modical Examinar must be redified at some. 10a. State 10c. City, Town or Location 10d. Inside City Limits S show...
I show and Mental Hygiene.
Is marked other than "natural", or items 23a or som...
Is marked other than "natural", or items 23a or som... Director 1 ☐ Yes 2X No West Africa Ghana Accra 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? PO Box A089 Funeral N/A Ghana Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 🛣 No Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ೭ Henry Sikafo Brown Lucy Mpiako-Mensah 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Agoagye (husband) PO Box A089, Accra, Ghana, West Africa 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 9 5 ☐ Other (Specify) 8/22/09 Awudone Cemetery Accra, Ghana 22. Name and Address of Facility Snowden Funeral Home, P.A. 21. Signatur of Funeral Service Licertse 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardo Pulmonary Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Acute Intracranial Hemorrhage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) ☐Yes 2¥ No this certificate has been signed by the all director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan was a... autopsy performed? Ves 2 No 2 🗆 No 1 ☐ Yes 1 □Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 11 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Katural death. To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0065505 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar QIUFANG

CHENG

32. Registrar's Signature

9901 Medical Center Drive.

		-	State of Maryland / Dep	artment of Health and Nertificate of Death		giene eg. No. o o o o	01.520
			Decedent's Name (First, Middle, Last)		2. Date of Deat Month	th Day Year	3. Time of Death
	Physicia /Medic		Jean Elizabeth Beaudea	an	July July	25 2009	0500 A M
· Day	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dear	th
			Union Hospital	Elkton If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Cecil	thplace (State or Foreign
	Funeral		5. Social Security Number  6. Sex 1 □ M 2 ☒ F  7. Age (In yrs. last birthday Yrs.	Months Days Hours Min.	JAN 6	(Year) Co	isiana
	Director		Usual Residence of Decedent		JAN O,	1750   100	
	yland now		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits 1 □ Yes 2 🕅 No
	Mar Ha-fsl	ctol	Maryland Cecil Elkton				
	or 28	Dire	10e. Street and Number	10f. Zip Code	1	10g. Citizen of What Co	
	ath w	Funeral Director	822 Jackson Hall School Road	21921	pocify Vee or No-	United S	
	item:	un:	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 ☒ No	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto	o Rican, etc.)	Black, Whit	e, etc.
336	ırs aft	þ	3 ☑ Widowed 4 □ Divorced Year or Dates:	1 □Yes 2 🔀 No Specify:		Specify: WI	nite
21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ent, the Medical Extrainer must be notified at	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation	kina I	16b. Kind of Business	/Industry
21	within 7 iene. <b>than</b> "r	nple	Elementary/Secondary (0-12)   College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)		D 11: C 1	1 D:
	filed wi Hygier ther th	ပိ		chool Bus Driver		Maiden Surname)	ool District
and	be fil ntal ⊦ ed otl	Be	17. Father's Name (First, Middle, Last)	Mary Sa		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Maryland	should be fi and Mental b is marked of aumatic eve	င္	Julian Herquet  19a. Informant's Name/Relationship (Type. Print)  19b. Mai	ling Address (Street and Number or Ru		er, City or Town, State,	Zip Code)
Ma	and 2 s ealth ar n 27 is ner trau		, 13,	Knob Hill Road, El			
ē,	s 1 and 3 of Health item 27 other tr		20a. Method of Disposition 20b. Place of Dis	position (Name of		20c. Location - City or	Town, State
E	Page nent c int: If		4 □ Donation 5 □ Other (Specify) R. A. Ferr	is & Co., Inc. 2009	9	West Ch	ester, PA
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Ext. of we must be notified at once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility. Licks Home for Fund 03 W. Stockton St	erals. P	. A .	21921
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not established, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death MARMON
,	/Medical Examiner  uh/sician and the prival-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	halopathy uctive Pulmonar	y Disa	ue	Unknown
P.O. Box 68760	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the bunal-transit	Completed by Physician/Medical	In the past 12 months?  1 □ Yes 2 ☑ No 9 □ Unknown  4 □ Pregnant at time of death 9 □ Unknown	B	23e Did to	23d. Date of d Month	Day Year
S,	res th	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Fart i.			Probably 4 ☑ Unknown
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ta	an: T tifical tor, pë	Be Co	25. Was case referred to medical	26. Place of De	1 ☐ Yes ath (Check only o		.5 2 1110
Į V	Physici this cer al direc		examiner? 1 ☐ Yes 2 ☐ No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	ient 3 DOA Other: 4 Nursing I	Home 5 ☐ Resid	dence 6 ☐ Other (Sp	ecify)
0 1	ding Physician: h. After this certific funeral director,	L:uc	27. Manner of Death 1 ☐ Natural 5 ☐ Pending (Month, Day, Year) 28a. Date of Injury (Month, Day, Year)	y Work?	28d. Describe	how injury occurred	
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	To the Hospital or Attene within 24 hours after death To the Funeral Director; completely filled in by the	dical Ce	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, de Check only one)  Medical Examiner: On the basis of examination and/or and manner stated.				as stated. ue to the cause(s)
	To the within To the Compl	Me	29b. Signature anglitle of certifier  Cuchclev-S-MD	29c. License number  30023322  e, Print)  ECST  ECST  Description in my opinion, death occurrence in my opinion in my op		29d. Date signed (Mo. 7.28.09	nth, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type S. S Sachdev MD 126A, E. H.	e, Print)  igh St Elhan	m2 2K	î2/.	
	Sta Regista		31. Date filed (Month, Day, Year)  JUL 31 2009  32. Red strar's Signature	face!			

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Sarah Beth Blakeley 7:00 15 2009 July р 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 18 Willow Drive Cecil Port Deposit | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nonths | Days | Hours | Min. | Dec. | 22, | 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday 1 ☐ M 2 ☑ F 216-76-4689 47 Dec. 1961 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☑ No Maryland Cecil Port Deposit 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18 Willow Drive 21904 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 □Yes 2 No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Twelve Years College (1-4or 5+) Personal Residence Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Howard L. Creswell, Sr. Sarah E. Perkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ricky E. Blakeley (Husband) 18 Willow Drive, Port Deposit, Maryland 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 07/21/09 Hopewell Cemetery Port Deposit, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, 21. Signature of Funeral Service License Shomasin 2 Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LUNG CANCEL TO BRAIN METASTATIC MONTHS Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23d. Date of delivery gnancy Month Day Year 23e. Did tobacco use contribute to the cause of death? se given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☑No 1 ☐Yes 2 ☑No 26. Place of Death (Check only one) examiner? 1 Yes 2 No

**Physician** /Medical Examiner

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Important: If itel
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**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show iny or other traumatic event, the "Medical Examinating out be notified at

Baltimore, Maryland 21215-0036

the Maryland

Examiner burial-tran Completed by Physician/Medical signed by the attending I be detached for use as this certificate has been s al director, page 2 should within 24 hours a er death.

To the Funeral Director After this certific completely filled in by the funeral director, Be Medical Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed

the

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Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 morns? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic prec 5 ☐ Other (spec
Part II. Other significant condition	s contributing to death but not resulting in	the underlying caus
25. Was case referred to medical		

Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

27. Manner of Death 1 Natural

2 Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 1155400D

29d. Date signed (Month, Day, Year) JULY 17, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

304-306 North Street Suite #3 ELATUN MARYLAND 21921 GAR-EL DAULO

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item# 7& 18 State of Maryland / Department of Health and Mental Hygiene Cecil Co. 7/22/09 riw Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 12:25 A 2009 Warren John Belay Ju<sub>1y</sub> 17 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 376 Old Mill Rd. Conowingo Ceci1 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1X1M 2□ F 53 Director 201-44-0743 Dec. 25, 1955 Pennsylvania Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits show r 28a-f show notified et 1 ☐ Yes 2X No Directo Maryland Ceci1 Conowingo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 376 Old Mill Rd. 21918 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (21) Yes 2 □ No If Yes, Give Year or Dates: "natural", or items dical Exeminer me Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 Divorced White Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) the Machine Operator Manufacturing other Department of Health and Mental Hyg Importent: If item 27 is marked other eny injury or other traumetic event, i 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Malinowski John William Belay 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Jones/Companion 376 Old Mill Rd., Conowingo, MD 21918 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Brookview Cemetery 7-24-2009 Rising Sun, Maryland 21. Signature of Funeral Service R.T. Foard Funeral Home, P.A. 111 S. Queen St., Rising Sun, MD 21911 Part1. Enter the discase, or complications that caused the scath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart from the control of the control o Approximate Interval Between Onset and Death Immediate Cause Final disease or con Pron resulting in th) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perforn 1 Yes 2 To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA s after death.

I Director: After this of in by the funeral d 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled Filled 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2192 Name and address of person who completed cause of death (Item 23a) (Type, Print) 6+IVA MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2009 Briscoe Louis Francis /Medical Facility Name (If not institution, give street and number County of Death 4b. City, Town, or Location of Death Examiner F MEDICAL ATA ENTER IVISTA Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2/24/1944 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Months 1**∑** M 2□ F Maryland 65 220-42-1779 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10b County 10c. City, Town or Location 10a. State th and Mental Hygiene. ? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 XYes 2 □ No Funeral Director Maryland Charles LaPlata 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 11615 Charles St 20646 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S.
Armed Forces?

Types 2 DNo 1 9 6 3
Ryes, Give
Year or Dates: 1 9 6 9 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 72 hours after 1 Never Married Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black Specify Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) be filed within Elementary/Secondary (0-12) College (1-4or 5+) Pepco Engineer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lucy Smith Briscoe P Austin Briscoe and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other tra Anna Williams Briscoe/Wife 1615 Charles st. LaPlata Maryland 20646 Health Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St.Marys Cath Ch. 7/20/2009 Bryantown MD 22. Name and Address of Facility 21. Signature of Suppral Service Lice They 20608 Adams Funeral Home PA, Aquasco MD 191 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence/of) Examiner 10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner executed (Ver Due to (or as a consequence of) attending physician a for use as the burial-Box 68760. pe Physician/Medical certificate IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) P.O. the 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 20 No 3 ☐ Probably 4 ☐ Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 🗆 No 1 TYes 1 ☐ Yes 2 ☐ 9 Hospital or Attending Physician: 24 hours after death. 9 Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check on and mann@r stated.

within 2

State Registrar

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Name and address of person who completed cause of death (Item 23a) (Type, Print)

ature and title of contifie

29b. Sign

30. Name and a Song C

29c. License number

7.C POSTOFFICE

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 0017 A M **Physician** 2009 0 ANN BENSON DEBORAH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner JICOMI Regional Medical Birthplace (State or Foreign Country) Date of Birth (Month, Day, **Funeral** Year) Min. 1 □ M 2 🗓 F MARYLAND 54 AUGUST 1954 Director 214-68-5062 10, Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, I've Medical Exandrar must be redtified at 1 ☐ Yes 2 X No Director MARYLAND WORCESTER BERLIN 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number death with 9330 CAREY ROAD 21811 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or Noif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status within 72 hours after 1 ∐Yes 2**X** No if Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE ⋧ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, In a Merican injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) **SECRETARY** EDUCATION 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be IRVING LYNCH LEE BAKER 2 W. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) RONALD W. BENSON/HUSBAND 9330 CAREY RD., BERLIN, MARYLAND 21811 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State BISHOPVILLE CEMETERY JULY 18, 2009 BISHOPVILLE, MD 21. Sign ture Tunerah Service Licens 22. Name and Address of Facility 19975 HASTINGS FUNERAL HOME, SELBYVILLE, DE Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of) Box 68760 attending physician Physician/Medical the as asn 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for 1 Month Year 5 ☐ Other (specify) P.O. ☐Yes 2☐No the 9 Unknown detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ pe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 : autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 **N**o Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient ÷ 1 Tes 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 ☐ Pending investigation To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aff completely filled in by the fur М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗌 Homicide Progritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier completed eause of death (Item 23a) (Type, Print 30. Name and address of person who SIMONA ENG nistrar's Signature 31. Date filed (Month, Day, Year) State 17 2009 Registrar

amend #F00 per Fire Sign in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deatl 2009 Physician 1940PM Edward B. Blevins /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** SAI(5b)
If Under 1 Year | If Under 24 Hrs. Peninsula Medical center Regiona 1 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1⊠M 2□ F 233-34-7696 07-07-1924 West Virginia Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County Worcester 10c. City, Town or Location 10d. Inside City Limits show 10a. State Department of Health and Mental Hygiene important; if item 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show all injury or other traumatic event, the Medical Exacilitar must be audited at once. 1 ☐ Yes 2 ☑ No Director MD Wicomico Salisbury 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 21804 U.S.A. 8035 Greenbriar Swamp Road Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: \$ 3 Widowed 4 Divorced white Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Church Minister 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Virgie Winfrey Edgar Clay Blevins ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21804 Gloria White Blevins 8035 Greenbriar Swamp Road Salisbury, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Laurel Hill Cemetery 07-18-2009 Laurel, Delaware permit. 22. Name and Address of Facility
Short Funeral Home 21. Signature of Funeral Service Licensee 13 East Grove Street Delmar, DE 19940 23a. Part 1. Inter the disease, or companies shock, o hear failure. List only Approximate Interval Between Onset and Death resimplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one caus. I each the Immediate Cau — ff inal disease or condition resulting in death) **Physician** nonia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): P.O. Box 68760, been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2 ☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performe certificate 2 🗆 No 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 (4No 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes ဥ 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the course of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the course of examination and/or investigation, in my opinion, death occurred at the time, date and place and place and place and place. Medical the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the basis of examination and/or investigation, in my opinion and of the cause of th To the I within 2 29b. Signature and title of certil 29c. License number 29d. Date signed (Month, Day, Year) 25a) (Type, Print) 30. Name and address of person who completed of death (Item 1413 31. Date filed (Month, Day, Year) 32. Regis frar's Signature State JUL 17 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	Ciato of Ma	•	ertificate of			leg. No.	100	21.53
	Physici	an	1. Decedent's Name (First, Middle, Las Melvin	it)	Bailey			2. Date of Dea Month July 12		Year	3. Time of Death 7:20 a M
	/Medio		4a. Facility Name (If not institution, give	street and number)	Dailey	4b. City, Town, o	r Location of Death		4c. County	of Death	
2	Exami		Casey House			Rockvill	.e		Montg	omer	y
	Funeral Director		5. Social Security Number 6. Si 231–36–9662 1  Usual Residence of Decedent	ex 7. Age SatM 2□F	(In yrs. last birthd	Months   Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Nov 30		Cour	lace (State or Foreign htry) Sinia
	land w		10a. State 10b. County		10c. City, Town or	Location				1	0d. Inside City Limits
	a-f sh	ctor	MD Prince (	George's	Bladens	burg					1⊠Yes 2□No
	or 28	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	itry?
	s 23a	eral	5802 Annapolis F			2071			USA		Indian
036	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it will deat Enrich at 1, 1 and 100 Enrich at 1, 200 Enrich at 2, 20	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	Airforce	<ol> <li>Was Decedent of F If Yes, specify Cubin</li> <li>Yes 2 No</li> </ol>	Ilspanic Origin? (S) an, Mexican, Puerto Specify:	Decity Yes of No- Display Rican, etc.)	Specif	ce - Americ ck, White, o y: B1a	etc.
21215-0036	hin 72 ho e. an "natui	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed) College (1-4or 5+	(G	ecedent's Usual Occup ive kind of work done e. DO NOT use retired	during most of work	king	16b. Kind of B	usiness/Ind	dustry
21	ed wit ygien her tha	Соп	Elementary/Secondary (0-12)		Tru	ck Driver			Privat		
land	uld be fill Aental H rked oth tic even	To Be	17. Father's Name (First, Middle, Last) William Edward B	ailey			18. Mother's Nam Ella Lou			ne)	
Maryland	alth and A		19a. Informant's Name/Relationship (7 Roberta Boone/sis		111	ailing Address (Street H Street,		ral Route Numbe nington,	-		Code)
Baltimore,	of He		20a. Method of Disposition 11 Burial 2 □ Cremation 3 □	Removal from State	20b. Place of Di cemetery, of	sposition (Name of crematory or other place	ce)	Date	20c. Location	- City or To	wn, State
Ĕ	tment tant: lant: l		4 ☐ Donation 5 ☐ Other (Specify	<i>'</i> )	MD Vete	rans Cemet			Chelten		
Ba	permit Depar Impor any In		27 Signature of Fun Service Licen			22. Name and Addre 7474 Lando	ver Road,	Landov	er, MD		
)	Physician /Medical Examiner		23a. Part1. Enter the disease, or compands, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a. Colon C			ng, such as cardiac	or respiratory an	rest,	1	Approximate Interval Between Onset and Death
	led isit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as a	consequence of):						
68760,	rtificate be executed ng physician and as the burial-transit	ledical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	consequence of):						
P.O. Box 68	The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of live birth and live birth a	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	у			ate of delive	ery Day Year
	quires that en signed b uld be deta	by	Part II. Other significant conditions of End Stage Rena	-	t not resulting in th	e underlying cause giv	ren in Part I.				ne cause of death?
Division of Vital Records,	: The law re cate has bee page 2 sho	Completed						24a. Was a autop perfor 1 ∐Yes	sy med?	Were auto prior to co death? 1 □ Yes	psy findings available mpletion of cause of
<u> </u>	sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		stiont 3 DOA Oth	26. Place of Dea				77 *
ion of	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filed in by the funeral director, page 2.	Certification: To	1  Yes 2  No 27. Manner of Death 1  Natural 5  Pending investigation	28a. Date of Injur (Month, Day	nt 2 ER/Outpa y 28b. Tim (Year) Inju	e of 28c. Inju	ry at	ome 5 Resid			y) Hospice
DIVIS	ial or Atte s after dea al Directol ed in by th	Certifica	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc.	ry - At home, farm, . <i>(Specify)</i>	street, factory, office		28f. Location (S City or Tow		ber or Rure	al Route Number,
	the Hospital or hin 24 hours afte the Funeral Dir npletely filled in	Medical (	29a. Certifier (Check only one)  1 ☑ Certifying Ph 2 ☐ Medical Exam	ysician: To the best on inner: On the basis of and manner sta	examination and/o	eath occurred at the ti or investigation, in my	me, date and place opinion, death occu	e, and due to the irred at the time,	cause(s) and made and place,	anner as s and due to	stated. o the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier  J. Koueut	· hall	mi	29c. Licens		:	29d. Date signe	ed (Month,	Day, Year)
							3748		Ju1y	13, 2	009
2	4		30. Name and address of person who Jocelyne T. Kou	atchou, 20	l East Un	niversity .	Parkway,	Baltimo:	ce, MD	21218	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	r's Signature						

		Please 1	<b>Type or Print in B</b> State of Maryland				_		7120	
		For State Registrar	State of Marylani	-	rtificate (			Reg. No.	2453	
ysici	an	Decedent's Name (First, Middle, Last,     Anna Atkinson					2. Date of Dea Month July	15, Day 2009 ear	3. Time of Death 6:25 P. M	
/ledic		4a. Facility Name (If not institution, give			4b. City, Tow	n, or Location of Dea		4c. County of Deat		
		Washington Adventist Hospital				Takoma Park Montgomery			mery	
eral ctor		5. Social Security Number 6. Security Number 239–12–3584  Usual Residence of Decedent	7. Age (In yrs. I M 2 1 F 92	a <i>st birthday)</i> Yrs.	If Under 1 Ye Months Da	ear If Under 24 Hr lys Hours Mir		y Ve <i>ar)</i> 916 Golds	hplace (State or Foreign untry) OOTO, N.C.	
Offied at	Completed by Funeral Director	10a. State 10b. County D.C.	10c. City	, Town or Lo Wash	ocation ington				10d. Inside City Limits  M☐Yes 2☐No	
ust be no		10e. Street and Number 1737 24th St., N.E.			10f. Zip Code 20002			10g. Citizen of What Country? U.S.A.		
any Injury or other traumatic event, the Madical Examiner must be notified at once.		11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1  ☐Yes 2 No tf Yes, Give Year or Dates:		Was Decedent If Yes, specify 1 □Yes 2★	of Hispanic Origin? Cuban, Mexican, Pue No <i>Specify:</i>	(Specify Yes or No erto Rican, etc.)	Specify: Af		
		15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give life.	dent's Usual O kind of work do DO NOT use re Homemal	one during most of w tired)	rorking	16b. Kind of Business/ Own Home	Industry	
	To Be Co	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)								
		19a. Informant's Name/Relationship (Type. Print)  Russell L. Barbee, Jr./Son  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  3005 Crest Ave., Cheverly, Maryland 20785								
		20a. Method of Disposition  1 Ma Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	ternoval from State		osition (Name of matory or other		Date /25/09	20c. Location - City or Washington		
any Inju		21. Signature of Funeral Service Licensee  22. Name and Address of Facility H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019								
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		23a. Part 1. Filer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):						Approximate Interval Between Onset and Death		
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discass or injury								
	= 1	that initiated events resulting in death) Last  C.  Due to (or as a consequence of):								
	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death 3   Ectopic pregnancy   23d. Date of Month   2   Pregnant at time of death   5   Other (specify)     Month   2   Pregnant at time of death   5   Other (specify)     Month   2   Pregnant at time of death   5   Other (specify)     Month   2   Pregnant at time of death   5   Other (specify)     Month   2   Pregnant at time of death   5   Other (specify)     Month   2   Pregnant at time of death   5   Other (specify)     Month   2   Pregnant at time of death   5   Other (specify)     Month   2   Pregnant at time of death   5   Other (specify)     Month   2   Pregnant at time of death   5   Other (specify)     Month   2   Pregnant at time of death   5   Other (specify)     Month   2   Pregnant at time of death   5   Other (specify)     Month   2   Pregnant at time of death   5   Other (specify)     Month   2   Pregnant at time of death   5   Other (specify)     Month   2   Pregnant at time of death   5   Other (specify)     Month   2   Pregnant at time of death   5   Other (specify)     Month   2   Pregnant at time of death   5   Other (specify)     Month   2   Pregnant at time of death   3   Pregnant at time						23d. Date of de Month	livery Day Year	
	d by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						Did tobacco use contribute to the cause of death?  1 Yes 2 1 No 3 Probably 4 Unknown		
	Completed					24a. Was an autopsy performed? 1 □ Yes 2 □ No		completion of cause of		
	Be C	25. Was case referred to medical examine? 26. Place of Death (Check only one)								
al dire	ဥ	1   Yes 2   No								
the funera	cation:	27. Manner Feath  1				Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred			
illed in by	Medical Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)								
pletely f	edical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
com	Σ	29b. Signature and title of certifier	Ft, Mi	)		cense number	100	29d. Date signed (Monitor)	th, Day, Year) - 17-09	

State Registrar

DHMH 17 Rev 1/2001

SILVEST

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Mozigizy

BLVD

Sast

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alfm Co.

32. Registrar's Signature

1. faula

31. Date filed (Month, Day, Year)

JUL 2 0 2009

09-05463 Shalico Varnae Balton

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2009 24537

		Registrar				cate of					Reg. No	·	- 12		
Physicia ≏al Exami	an/	1. Decedent's Name (First, Midd <b>Shali</b> e	1ton			2	Date of De Month July 12,	200 <del>9</del>	Year		3. Time o 1457				
		4a. Facility Name (if not institution Prince George's Hosp	-	and number)		4	b. City, Town, or Cheverly	Location of	Death			Prince G		s	
Funeral Director		5. Social Security Number	6. Sex		in yrs. last bi		If Under 1 Yea Months Days		24Hrs. Min.		•	1978	Foreign	Wash	ate or ington
Director		577-02-8831 Usual Residence of Decedent	1 M 2	AF .	31	Yrs.		<u> </u>		Janua	ary	12,			
ow any		10a. State 10b. County			Dc. City, Tow										de City Limits es 2 No
ne Maryland or 28a-f show	Director	District of Co	OTUMD1	a	W	ashin	10f. Zip Code				10g. C	itizen of Wh	at Count	ry?	
the Ma 3a or 2		3538 "A" Str					2001					nited			-
5, MID £1£19-U030 and 2 should be filed within 72 hours after death with the Maryland featth and Mental Hygiene. trem 27 is marked other than "natural", or items 23a or 28a-fish tramatic event, the Medical Examiner must be notified at once	Funeral		Married A		ver in U.S.	If Ye	s Decedent of His es, specify Cubar	n, Mexican,	in? ( Spe Puerto R	cify Yes or I lican, etc.)	No-	14. Race White	e, etc.	an Indiar Lack	
rs after ural", miner	à	3 Widowed 4 Di	vorced If Yes, or Da	es:	leted) 16a		Yes 2 X No		aind of wo	ork done	16b	Specify: o. Kind of Bu	siness/In	dustry	
72 hou n "nate al Exa	Completed	Elementary/Secondary (0-12)		ollege (1-4 or 5+		during me	ost of working life	. DO NOT			W	orking	or Am	oric	2
5-UU30 iled within 72 Hygiene. I other than "	ᇤ	12th grade				Heal	th Care		e Name /	First Middle		en Surname	_	CIIC	a
Z13-( Z13-( Z1 De filed v ntal Hygi rked oth ent, the	Be C	17. Father's Name (First, Middle Michael Was		n Balt	on					Jean			,		
should be filed with and Mental Hygiene 7 is marked other th		19a. Informant's Name/Relation			I		9 Address (Stree								
Battimore, MD Z permit. Pages I and 2 should Department of Health and Mc Important: If item 27 is mainjury or other traumatic er		Toni Jean Mu	se (Mo	ther)	20b. Place	3538 e of Dispos	"A" Stre	eet,S metery,		Date	20	c Location -			
Baltimore, IM permit. Pages   and 2 Department of Health Important: If item 2 injury or other traum		1 X Burial 2 Crematic		moval from Stat	e crem	natory or oth	herplace) <b>Memorial</b>			າ ີ 24 <b>,</b> 2		uitla:	nd 1	Marv	1and
mit. Pasartmer		Donation 5 Other 8	Specify: eysee	N			Name and Addres								
ii ii Per	1	Sandas	he	Hau	17	In	ic.;600	Kenne	dy S	treet	, N. V	V.;Was	hing	ton,	D.C.20
Physician		23a. Part I. Enter the disease, of	r complicatio						ardiac or						
Medical		failure. List only one caus	e on each line	€.			he mode of dying	, 3001 83 0		, ,	a., 001, 1	one or the	ait		en Onset and Death
		Immediate Cause (Final diseas or condition resulting in death)	e on each line e a. <mark>Pulm</mark>	nonary Thror o (or as a consec	nboembo		he mode of dying								en Onset and
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8760,  rificate be executed may be a graphysician and as the burial - transit	by Physician/Medical Examiner	Immediate Cause (Final diseas or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in past 12 months?	e on each line e a. Pulm Due to b. Due to d. AM the 23 1 1 4 nknown 9	e. nonary Thror o (or as a consect o (or as a consect o (or as a consect consect ENDED c. If yes, outcom Live birth Pregnant at t Unknown	nuboembo quence of): quence of): quence of): e of pregnan ime of death	lism	etal death 3 ther (Specify)	Ectopi	c pregnar	23e. D	id tobac	23d. Date o Month	of delivery	Day the caus	en Onset and Death
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month 2308 2009 Walter Malcolm Beall III 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Dorches Cambridge HOSAMa. General XXChater If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 X M 2 □ F 16, Dec. 1940 213-38-9358 68 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Cambridge MD Dorchester 1 Dayes 2 □ No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 427 Robbins Street 21613 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 【XNO Black, White, etc. 1 □ Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates Specify Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) assistant manager antique store 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Walter M. Beall Jr. Eileen Mahala 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Beall wife 427 Robbins St., Cambridge, MD 21613 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Salisbury Crematory 7/21/09 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Septice ic 700 Locust St., Cambridge, MD 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CROMARY Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 **2** 20 es 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 □Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Natural

The law requires that the death certificate be executed and Box 68760. o ۵. Records, peen certificate of Vital Physician:

burial-trar physician a the burialattending p signed by the a d be detached f cate has page 2 s this After thi n 24 hours after death.

Re Funeral Director: After the further of the further of

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

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**Physician** 

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Certification:

Medical

State Registrar

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Director

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Completed

other traumatic event, the Medical Examiner must be notified

Baltimore, Maryland 21215-0036

Brall

To the Hospital within 2 To the I

Division or Attending

29b. Signature and title of certifier

2 Accident

3 Suicide

29a, Certifier

4 Homicide

and manner stated.

6 □ Could not be determined

28a. Date of Injury (Month, Day, Year)

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Dat¶ signed (Month, Day, Year)

re Suitel

28d. Describe how injury occurred

28c. Injury at

28f. Location (Street and Number or Rural Route Number, City or Town, State)

cause of death (Item 23a) (Type, Print) 30. Name and aurress of person who comp ewmies 2

Year)

5 ☐ Pending investigation

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) Randolph Henry Bellman, Jr. 2. Date of Death 3. Time of Death Day 2009 **Physician** July 15, 5:50 a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Oct. 12, 1923 5. Social Security Number 7. Age (In yrs, last birthday, 9. Birthplace (State or Foreign **Funeral** Sex 1∐M 2□F Days Min. Months Hours Washington, DC 577-22-0874 85 Yrs Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits show la or 28a-f show the notified at 1 ☐ Yes 2☐No Director Maryland Bethesda Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 20814 USA 5225 Pooks Hill Road, Apt. 725 South ms 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Examiner Pages 1 and 2 should be filed within 72 hours after of health and Mental Hygiene. ant If Item 27 is marked other than "natural", or iten uny or other traumatic event, ITEM MAIDEL Examinating or other traumatic event, ITEM MAIDEL Examinating or other traumatic event, ITEM MAIDEL Examinating or other traumatic event, ITEM MAIDEL Examinations. 1 Never Married 2 Married 1 ☐ Yes 2 🔼 No Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Car Dealership Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pearl Hamilton Randolph H. Bellman, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19a. Informants Name/Heladoniship (1978) Sharon L. Martindale/StepGranddaughter 4101 Conger Street, Silver Spring, MD 20906 Department of Health Important: If Item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition July 16 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory Alexandria, Virginia d 2009 4 ☐ Donation 5 ☐ Other (Specify) Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiac Arrest **Physician** /Medical Due to (or as a consequence of): **Examiner** Cardiac Arrhythmia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Myocardial Infarction and burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 C Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □ No 24a. Was an autopsy performed? Yes 2 🙀 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) 1 Yes 2 No 1 🔼 Inpatient 2 ER/Outpatient 3 DOA funeral 28b. Time of 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death. the

Hospital or Attending Physician; The law raquires that the death certificate be executed Division of Vital Records, P.O. Box 68760, attending physician for use as the buria nis certificate has been signed by the director, page 2 should be detached this After

death with the Maryland

Baltimore, Maryland 21215-0036

Certification: To

2 Accident 3 Suicide 4 Homicide

(Check only one)

29a, Certifier

2 Media

6 Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manyer stated. 29b. Signature and the

D67589

29d. Date signed (Month, Day, Year) July 15, 2009

30. Name and andress of person who completed cause of death (Item 23a) (Type, Print)

1500 Forest Glen Road, Silver Spring, MD 20910 MD Harold Lawson,

State Registrar

filled in by

completely

Medical

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31. Date filed (Month, 174)

32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	Olalo of IV	iai yiai ic		rtificate of L		•	Reg. No.	009	245	40
			1. Decedent's Name (First, Middle, L	ast)					2. Date of De Month	ath Day	Year	3. Time of D	eath
п	Physicia /Medic			loyce Florence	e Benne	ett			July	15	2009	1240	M
· )	Examin		4a. Facility Name (If not institution, g.	ve street and number	)		4b. City, Town, or	Location of Dea	ith	4c. Cou	unty of Death		
3			Holy Cross Hosp				1	ilver Spri			Montgo		
ł	Funeral Director		241-15-0736	Sex 7. Ag 1 □ M 2 🗷 F	ge (In yrs. la 56	Ven	If Under 1 Year Months Days	If Under 24 Hr Hours Min		th ay, Year) <b>9, 1953</b>	Coun	lace (State or try) a Leone	Foreign
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation				10	Od. Inside City	Limits
	Maryl f sho	ģ	Maryland Montgo	merv			P <sub>e</sub>	otomac				1 ☐ Yes 2	2 <b>≰</b> No
	r 28a	Director	10e. Street and Number	mer y			10f. Zip Code	COMOC		10g. Citizen	of What Coun	try?	
	h with		10112 Sorrel Ave	nue				20854			U.S.A.		
	deat	Funeral	11. Marital Status	12. Was Decedent Armed Forces	t Ever in U.S	. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? ( n. Mexican, Pue	Specify Yes or No	)- 14.	Race - Americ Black, White, 6		
21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show raumatic event, The Madical Eventine in as the resilied at	þ	1 ☐ Never Married 2 🗷 Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 <b>∑</b> If Yes, Give Year or Dates:	No		1 □Yes 2 <b>⊠</b> No	Specify:	,		ecify:	Black	
2-0	72 ho natur	Completed	15. Decedent's I	Education rade completed)		(Give	dent's Usual Occup	luring most of wo	orking	16b. Kind	of Business/Ind	lustry	
21	han "	du l	Elementary/Secondary (0-12)	College (1-4or	5+)	`life.	DO NOT use retired	) -					
2	Hygie Hygie Ther t	ပ္ပ	17. Father's Name (First, Middle, Las	5+			01110	ce Manager	r ame (First, Middle	. Maiden Su	Medica	<u></u>	
Maryland	d be f	Be c		t Boston				10. 11101101011	,	Thomas	,		
Z	should nd Me mark	은	19a. Informant's Name/Relationship			19b. Maili	ng Address (Street	and Number or F			wn, State, Zip	Code)	
<u>8</u>	nd 2 salth al		Oliver Bennett - H				2 Sorrel Av						
re,	s 1 al		20a. Method of Disposition		20b. Pla		osition (Name of matory or other place	_	Date		ion - City or To	wn, State	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked of any Injury or other traumatic every once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	ify)	<i>†</i>	e of He	eaven Cemete  2. Name and Addres	ery 07	//22/2009	Silver	Spring,	Marylan	ıd
Ba	Depa impo any i	. 4	21. Signature of Funeral Service Lice	ensee ,		1	Hines-Rinald 11800 New H	di Funeral	l Home, Ind	C. Ivor Snr	ring Mar	vland 20	190/
			23a. Part 1. Enter the disease, or co								1116, 1111	Approximate Interval Betw	
is .	Physician	1	shock, or heart failure. List onl		monary	Hyport	encion					Onset and De	eath
	/Medical		disease or condition resulting in death)	a	s a consequ		enston						
	Examiner		Conventially list conditions	b. Sar	coidosi	.s							
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		s a consequ	ence of):							
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C									
60,	be ex		Todaling in doubly Edot	Due to (or as	s a consequ	ence or):							
68760,	ficate be executed physician and s the burial-transit	Medical		d									
×	certifii nding p		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnar	псу				230	I. Date of delive	erv	
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/I	in the past 12 months?  1 ☐ Yes 2 🗷 No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	at time of de		☐ Ectopic pregnanc ☐ Other (specify)	у			Month	-	e ar
σ.	res that the de signed by the a be detached		Part II. Other significant conditions	contributing to death	but not resul	Iting in the u	inderlying cause giv	en in Part I.	23e. Did	tobacco use	contribute to the	ne cause of de	eath?
Records,	quires n sigr ild be	d by							10	Yes 2□ N	No 3 ☐ Prob	ably 4 🗶 U	nknown
000	w require s been siç should b	Completed							24a. Was		24b. Were auto	– psy findings a	vailable
Re	'siclan: The law s certificate has l irector, page 2 s	шo								ormed?	death?	mpletion of ca 2 □No	use of
ta	an: ] rtifica tor, p	Be C	25. Was case referred to medical	T				26. Place of De	1 ☐ Yes eath (Check only		TLITES	2 🗆 1110	
<u> </u>	> 22 0		examiner? 1 ☐ Yes 2 🔼 No	Hospital: 1 ☐ Inpat	tient 2 🔼 E	ER/Outpatie	nt 3 DOA Oth	er: 4 \(\sime\) Nursing	Home 5 ☐ Res	idence 6	Other (Specif	y)	
Division of Vital	ne fte	Certification: To	27. Manner of Death 1   Natural 2   Accident  Pending investigati	28a. Date of In (Month, D	jury Pay, Year)	28b. Time o Injury	Worl	yat ⟨? Yes 2 □ No	28d. Describe	how injury o	ccurred		
ivisi	- = e -	rtifica	3 Suicide 6 Could not determine	be d 28e. Place of Ir building, e	njury - At hor etc. <i>(Specify</i>	me, farm, st	reet, factory, office		28f. Location ( City or To	(Street and N wn, State)	lumber or Rura	l Route Numb	ber,
	Hospital or 24 hours afte Funeral Dir tely filled in			Physician: To the bes									
	To the Hospital c within 24 hours af To the Funeral D completely filled i	Medical	29b. Signature and title of certifier	and manner s		λ	29c. Licens		a die iiie		signed (Month,		
B	6		1 /	no	1	4	>	D41624			July 15	, 2009	
	<u> </u>		30. Name and address of person wh	(1									
			G. Patrick Murphy, 31. Date filed (Month, Day, Year)	32 Regis	Forest trar's Signat		oad, Silver	Spring, N	Maryland 20	0910		<del> </del>	
	Sta Registr		JUL 17		_		bares						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink Epsuse All Copies Are Legible.

Amend Item 29d per phys. 6894 8/13/03/16 Gopies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 1248 4 July Barton Maynard Bartholomew 21 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany WMHS-Memorial Campus Cumberland If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month) Days | Hours | Min. | Nov. 2 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Pennsylvania 1 X M 2 □ F 1917 91 Yrs. 215-14-0488 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show ?7 Is marked other than "natural", or Items 23a or 28a-f shor traumatic event, the Medical Event net hust be not the a 1 ☐ Yes 2 X No Director WV Fort Ashby Mineral 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with USA 26719 HC-86, Box 5 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □Yes 2▼ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Specify: White 2 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) n and Mental Hygiene. Is marked other than Barge Company Welder 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Roxanna Shelton David Earl Bartholomew 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If Item 27 Is any Injury or other trau 15001 Hilltop Dr., Fort Ashby, WV Carolyn A. Horner/Daughter 26719 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State July 25, 2009 Friendsville, MD 4 □ Donation 5 □ Other (Specify) Humberson Cemetery 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licensee P.O. Box 275, Grantsville, MD Approximate Interval Between Onset and Death 23a. Part1. Em at the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock. In leart failure. List only one cause on each line. immediate Cause (Final disease or indition resulting in death) Physician des no /Medical Due to (or as a consequence of): Examiner howales Sequentially list conditions, if any, leading to infinitely accesse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation after death.

Director: Af d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

0

JUL 24

31. Date filed (Month, Day, Year)

V. Poonai M.D

924 Seton 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cumberland, MD. 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Vear **Physician** 4:00 A M RUBY G. CAULFORD 25 2009 July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford 1320 Grafton Shop Road Bel Air Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours Min. 102 3,1907 Virginia June Director 215-54-4981 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10h County 28a-f show traumatic event, the Medical Exeminer must be notified at 1¥∑Yes 2 □ No Director MD Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with ö 21014 Harford 1320 Grafton Shop Road 23a Funeral death 1 items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 9 1 ☐ Yes 2 ☐ No Specify: <u>Ş</u> 3 XWidowed 4 ☐ Divorced "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) þe Jane Wingate John A. Halsey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any Injury or other trau 1320 Grafton Shop Road, Bel Air, MD 21014 Connie Wallace/granddaugh. Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/29/09 Darlington, MD Dublin So. Cem. 4 Donation 5 Other (Specify) 21. Signature of Morelal Service Lio 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA17314 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ischemic Heart Discuse years **Physician** disease or condition resulting in death) ) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transi and Due to (or as a consequence of): Box 68760, ending physician use as the buria certificate be Physician/Medical attending 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 힏 in the past 12 months? 5 Other (specify) Yes 2 No o 9 Unknown signed by ti ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 performed? 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours aller death.

To the Funeral Lirector After this certifica completely filled in by the funeral director, p. 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 ☐ Natural 2 ☐ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 □Yes 2 □ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

DK

**ORIGINAL** 

413 North Ave.

Pegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vincent Agiminaro, Do

31. Date filed (Month)

HD0521439

Bel Au, MD 21014

27,2009

		1	State of Maryland / Department	artment of Health and N rtificate of Death		glerie 009 24543	
		_	Decedent's Name (First, Middle, Last)		2. Date of Dea Month	Dav Year	
	Physicia		James Joseph Carrigan		July 1		
-	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
1			418 Hillsmere Drive	Annapolis	Ta Data (Dish	Anne Arundel	
	Funeral		5. Social Security Number 6. Sex 7. Age ( <i>In yrs. last birthday</i> ) 220−16−7758 1√2 M 2□ F 82 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day	(, Year) Country)	
	Director	-	220 10 7730		9/9/1	1926 Marylan	d
	and w	ŀ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits	
	Maryl f sho	0	Maryland Anne Arundel Annapo	olis		1 □Yes 21v No	
	the t	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?	
	3a or		418 Hillsmere Drive	21403		USA	
	ms 2	Funeral	12 Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Spirit Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-		
39	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Exprintment must be notified at or other traumatic event, the Medical Exprintment must be notified at	þ	1 Names Married 2 Narried 1 Naves 2 No	1 □Yes 2 No Specify:	, i noan, otoly	Specify: White	
15-0036	"natura "natura	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) ((Give	edent's Usual Occupation a kind of work done during most of worl DO NOT use retired)	king	16b. Kind of Business/Industry	
2121	ould be filed within 3 Mental Hygiene. narked other than natic event, the Ma	mg	Flomonton/Conondany (0.12)   College (1-40r.5+)	ırance Agent		Insurance	
<b>d</b>	Hygi Hygi other ent, I	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle,	Maiden Surname)	
an	ld be lental ked o	To B	Harold Carrigan	Miri	am Coope	er	
ary	shou and N s mai		19a. Informant's Name/Relationship (Type. Print) 19b. Maili	ing Address (Street and Number or Ru	ral Route Numbe	er, City or Town, State, Zip Code)	
Σ	and 2 ealth is			Hillsmere Drive,			_
Baltimore, Maryland	permit. Pages 1 au Department of Hee Important: If Item any Injury or othe once.		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposemetry, cre Hillcres	osition (Name of matory or other place) st Mem. Gardens 7/	Date 16/2009	20c. Location - City or Town, State Annapolis, MD	
Balti	permit. Pages Department of I Important: If Ite any Injury or o once.	J. I	Muslin T. Weller	147 Duke of Glouce	ster St.	aylor Funeral Home, In ., <u>Annapoli</u> s, MD 21401	
	Physician /Medical Examiner	e.	23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate  Due to (or as a consequence of):	There schero	the property and the pr	rrest, Approximate Interval Between Onset and Death	
68760,	ficate be executed physician and s the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):				
O. Box	death certifi e attending d for use as	Physician/Med		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year	
ds, P.	requires that the de een signed by the a nould be detached f	ē	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		obacco use contribute to the cause of death? Yes 2 □ No 3 □ Probably 4 ☑ inknown	n
of Vital Records,	law as b 2 st	Completed			24a. Was autoj perfo 1 □ Yes	an psy prior to completion of cause of death?  2 DNo 1 DYS 2 DNo	е
ita		BeC	25. Was case referred to medical examiner?		ath (Check only o	one)	
<u></u>	Physic this ce al dire		1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati			idence 6 Other (Specify)	
ם	Jing P	ë	27. Manner of Death 1		28d. Describe	how injury occurred	
Division	or Attending Physician: fter death. Nrector: After this certific in by the funeral director, in	Certification: To	2 Accident investigation 3 □ Suicide 6 □ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		28f. Location ( City or To	Street and Number or Rural Route Number, wn, State)	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical Ce	29a. Certifier (Check only one) 1.7 ertifying Physician: To the basis of my knowledge, deadlors on the basis of examination and/or and manner stated.	ath occurred at the time, date and plac investigation, in my opinion, death occ	e, and due to the urred at the time,	e cause(s) and manner as stated. , date and place, and due to the cause(s)	
	To the within to the comple	Mec	29b. Signature/and title of certifier	29c. License number	43	29d. Date signed (Month, Day, Year)	
7	HINH		30. Name and address of person who completed cause of death (Item 23a) (Type Howard D. Gold Stern)	e, Print) 1/6 De	fense	they Annan. me	1
	St Regist	ate rar	31. Date filed (Month, Day, Year)  JUL 16 2009  32. Redistrar's Signature	pare	(		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2009 Year Physician 6:15 P Angelo Martino Conti July 16, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Riderwood Renaissance Center Silver Spring Prince George's Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Months Min. Hours 1 ₩ M 2 □ F Yrs Aug 19, 1914 Hartford, 94 Director 047-10-0468 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location show 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Evacotrar must be nothing at 11∏Yes 2 No Director Silver Spring Maryland Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 20904 3148 Gracefield Road, #524 USA death v Funeral 14 Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Mudfell Ever-1 ☐ Never Married 2 ☐ Married ☐Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White Specify: Specify: þ 3₺ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MVA - State of Elementary/Secondary (0-12) College (1-4or 5+) Connecticut Motor Vehicle Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis Conti Rose Martino ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7407 Baylor Ave., College Park, MD 20740
Lice of Disposition (Name of Date 20c. Location - City or Town, State Richard N. Conti - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crematory 7/17/09 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. RAG Rogers Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Chronic Kidney Disease 5 years **Physician** /Medical Due to (or as a consequence of): Examiner High Blood Pressure 10 years Sequentially list conditions, it any, leading to him edite cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duy to for as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, aftending physician for use as the burla Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) □Yes 2□No been signed by the should be detached 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has birector, page 2 s autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🔯 No this certific al director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 

Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 XNatural To the Hospital or Attendin within 24 hours after death, To the Funeral Director: Af completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

31. Date filed (Month, Day, Year) State JUL 2 0 2009 Registrar

Dr. Mark Parkhurst

29a. Certifier

Medical

3112 Gracefield Rd, Silver Spring, MD 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D24093 29d. Date signed (Month, Day, Year)

7/17/09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last)  $J_{u}^{Month}$  15, Day 009 Year **Physician** 2:25 рΜ Michael Lawrence Cisar /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery 19525 Gunners Branch Road, Apt. K Germantown 8. Date of Birth (Month, Day, Year) 0ct. 14,1948 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 5. Social Security Number Sex 1 M 2 □ F **Funeral** Hours Months Days Min. Pennsylvania Oct. 60 173-38-9469 Director Usual Besidence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Medical Examinat must be notified at 10d. Inside City Limits 10c. City. Town or Location 10a State 1 ☐ Yes 2 No Director Germantown Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number United States 20876 19525 Gunners Branch Road, Apt. K Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No 1974— If Yes, Give Year or Dates: 1977 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 No Specify Specify: White ò 3 Widowed 4 XDivorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Washington Suburban Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Sanitary Commission 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary (Unknown) Joseph Cisar ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2087619a. Informant's Name/Relationship (Type. Print) Michelle Marie Thomas (Daughter) 19525 Gunners Branch Road Apt.K Germantown, MD Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Ju1v 16, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Alexandria, VA Metropolitan Crem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funera Serv 10 East Deer Park Dr. Gaithersburg, MD 20877 M00689 M00689 TO East Deel Talk D1. Gallette and the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, expect, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction **Physician** /Medical Due to (or as a consequence of): Examiner Insulin Dependant Diabetes Mellitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner the death certificate be executed and the burial-tra Due to (or as a consequence of) Box 68760. physician Physician/Medical use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day jo in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No o 9 Unknown detached è σ. law requires that s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Hyper Cholesterolemia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has N autopsy performed page 1 ☐Yes 2 ☐No 1 □Yes 2 X No certificate 25. Was case referred to medical 26. Place of Death (Check only one) director Be examiner' Other: 4 Nursing Home 5 TResidence 6 Other (Specify) Hospital: 1∭XYes 2☐No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After thi funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? or Attending Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death.

To the Funeral Director; A completely filled in by the fu Investigation hours after death. 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 16, 2009 D33677 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20500 Seneca Meadows Pkwy. Suite#2400 Germantown, MD

State Registrar M.D.

Registrar's Signature

Edward J. Devin

31. Date filed (Month

Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 0<sup>Ye ar</sup> 24 **Physician** 2350 М. Dawson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** WMHS BRADDOCK CAMPUS CUMBERLAND ALLEGANY 9. Birthplace (State or Foreign Country) MD Date of Birth (Month, Day, Year) Sep 12, 1932 7. Age (In vrs. last birthday) Social Security Number **Funeral** Months Days Hours Min 1 M 2 J 212-30-7766 Director 76 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f shov Examiner must be notified at Allegany MD Cumberland 1 ☐Yes 2 ☐ No Director Pages 1 and 2 should be filed within 72 hours after death with the I ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28auny or other traumatic event, it is inselied. Exeminer must be notifi-10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21502 6 Forest Drive USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify. Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Instructor/supervisor Board of Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry R. Jackson Geraldine Peppler Morris မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert Dawson 6 Forest Drive MD 21502 Cumberland husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State Sunset Memorial Park 7/28/2009 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service License 108 Virginia Avenue: Cumberland, MD 21502 23a. Port 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760. Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 51 24a. Was an s certificate has t irector, page 2 s autopsy performe 1 ☐Yes 2 XNo within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, i 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 💇 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signatur d title of certifie 29c. License number 900cm

State Registrar DR. Blanche

DHMH 17 Rev 1/2001

DX

Seton Drive Cumberland, MD 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAVROMATIS 32. Regi**n**frar's

Hospital or Attending Physician: The law requires that the death certificate be executed 4th hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760, 24 hours a within 2.

death v

Pages 1 and 2 should be filed within 72 hours after

ltimore, Maryland 21215-0036

CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated.

29b. Signature and title of certifier

29c. License number D0041587 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Helen A. Noble, M.D. 122 Speer Rd. Chestertown, MD. 21620 31. Date filed (Month, Day, Year)

State Registrar

completely

Medical

32. Registrar's Signature

6

24

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2009 **Physician** July 19, 9:00 Annabelle Dombrowsky /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Goodwill Mennonite Home Grantsville Garrett 8. Date of Birth (Month, Day, Ye July 14, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** Year) Days 1 □ M 2 🔀 F 98 1911 Pennsylvania Director 169-26-5043 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 No Funeral Director PA Washington New Eagle 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 445 4th Avenue 15067 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Miller ္ပ Mary Borland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Jean Papik P.O. Box 83, Springs, PA 15562 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Monongahela Cemetery July 23, 200 Monongahela, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funenal Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) ongest /Medical Due to (or as 1 consequence of): Examiner Irdo m if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕅 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknowd Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy his certificate h 1∐ Yes 2⊠ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Division or Vital Records, P.O. Box 68760 within 24 hours after death

To the Funeral Director: A

> State Registrar

Medical

31. Date filed (Month, Day, Year) JUL 21 2009

Muhammag

29b. Signature and title of certifier

ecom 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only one)



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

		_	For State Registrar	State of M	aryland / Depa <i>Cei</i>	artment of Hertificate of L			ene g. No: 0 0 9	24549
			Decedent's Name (First, Middle, La	ist)				2. Date of Death	Day Yea	3. Time of Death
	Physicia		WAYNE	177	Dur	CT		Month 7	19 00	
	/Medic Examin		4a. Fecility Name (If not institution, gir	re street and number)	0 90.12		Location of Death		4c. County of De	eath
	Examin	er	33482 Garri		4: 12.10	Acci	ident		Gar	eH
	Francial				ge (In yrs. fast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Year) 9. E	Birthplace (State or Foreign Country)
	Funeral Director		214-36-6605	1 <b>₩</b> M 2□F	70 Yrs.	Months Days	Hours Min.	May 1,	1939 Ma	aryland
		l	Usual Residence of Decedent							T
	yland		10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
	Mar.	tor	MD Garret	t	Acciden	t				1 ☐ Yes 2 🔀 No
	7.284 1.00	Director	10e. Street and Number			10f. Zip Code		10	og. Citizen of What	Country?
	72 hours after death with the Maryland Insturat, or Items 23a or 28a-f show Ucal Examiner must be notified at	<u>=</u>	33482 Garrett H	ighway		2	1520		USA	
	deat	Funeral	11. Marital Status	12. Wes Decedent Armed Forces	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp. Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian, /hite. etc.
9	after or ite	7	1 ☐ Never Married 2 ☐ Married	1 X Yes 2	No	1 ☐ Yes 2 █ No	Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify:	white
္ထ	Surs.	1 by	3 ₩ Widowed 4 Divorced	Year or Dates:	Vietnam					
21215-0036	72 h	Completed	15. Decedent's 8 (Specify only highest gi		(Give	dent's Usual Occupa kind of work done of	during most of work	ing	16b. Kind of Busine	ess/Industry
2	within ene. then	du	Elementary/Secondary (0-12)	College (1-4or	5+) //fe.	DO NOT use retired	)			
	od w ygjer t,	ပိ	9 th		Seli-	employed	18. Mother's Nam		Orywall H	anging
Б	d oth	Be	17. Father's Name (First, Middle, Las	t)						
<u>×</u>	Men Men arke	ပ	Edison Durst					Bittinger		7:- O- d-\
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Heath and Mental Hygiene. If Heath and Mental Hygiene a natural; or Items 23a or 28a-f show them 27 is marked other than "natural; or Items 20 is notified at other traumatic event, the Medical Examinar must be notified at		19a. Informant's Name/Relationship Aaron W. Durst/			ng Address (Street a			20175	e, ZIP Code)
≥,	permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any injury or other trau								20c. Location - City	or Town State
Baltimore	of H of H of H		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3	Removal from State	20b. Place of Dispo cemetery, cre	matory or other plac	e)			
Ē	Pag ment ant: I ury o		4 □ Donation 5 □ Other (Spec		Country	Side Crema	atory Jui	y 22,09	Davidsv	ille, PA
at	porti		21. Signature of Funeral Service Lice	ensee	2	2. Name and Addres	ss of Facility Ne	ewman Fur	neral Hom	es, P.A.
Δ	82589			uman						e, MD 21536
			23a. Part1. Enter the disease, of conshock, or heart failure. List on	nplications that cause y one cause on each	d the death. Do not en line.	ter the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Pnysician	3	Immediate Cause (Final disease or condition		niosceno	1/10rows	w vas	ulard	1848	Onset and Death
	/Medical		resulting in death)	a. Due to (or a:	s a consequence of):	1200.010	1			
	Examiner		O	b						
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		s a consequence of):					
	ansil	Examiner	Cause (Disease or injury that initiated events	С.						
oʻ	exectan and arright.		resulting in death) Last	Due to (or a	s a consequence of):					
8760,	certificate be executed Iding physician and Ise as the burial-transit	dlcal		d						
9	tifica ng ph as th	led								
Вох		Ş	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		⊒Ectopic pregnancy	,		23d. Date of Month	delivery Day Year
	0 0 0	by Physician/Me	in the past 12 months? 1 □ Yes 2 □ No			Other (specify)			Month	Day
P.0	by th	hys	9 Unknown	9LI OHKHOWII						
	w requires that s been signed b should be det	Jy P	Part II. Other significant conditions	contributing to death	but not resulting in the o	inderlying cause give	en in Part I.	1/1		te to the cause of death?
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ပ္ပ	> 0 0	Completed						24a. Was a	n 24b. Wer	e autopsy findings available to completion of cause of
æ	0 2 0	E					· ·	perforr	ned2 deat	h? Yes 2□ No
<u>a</u>	ician: The certificate rector, pag	a	25. Was case referred to medical				26. Place of Dea	th (Check only on		
>		To B	examiner? 1 ✓ Yes 2 ☐ No	Hospital: 1 Inpat	ient 2 ER/Outpatie	nt 3 DOA Oth	er: 4 Nursing H	ome 5 Reside	ence 6 Other (	Specify)
of			27. Manner of Death	28a. Date of In (Month, D		of 28c. Injury Wor	y at	28d. Describe ho	ow injury occurred	
e G	ding F th. : After s funera	i i	1 Natural 5 Pending 2 Accident investigat		ay Year) Injury		Yes 2 □ No			
Division of Vital Records,	Attending r death. ector: Afte by the fune	fice	3 ☐ Suicide 6 ☐ Could not	288. Place of 1	njury - At home, farm, st	reet, factory, office		28f. Location (St City or Town	treet and Number o	r Rural Route Number,
Ö	after Dire	Certification:	4  Homicide	bullaing, e	etc. (Specify)			Only or Your	1, 0.010)	
	spite nours nera fille	<u>a</u>	29a. Certifier Certifying	Physicien: To the bes	t of my knowledge, dea	th occurred at the tir	ne, date and place	and due to the ca	ause(s) and manne	er as stated.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ledical	(Check only 2 Medicel Ex	aminer: On the basis and manner:	of examination and/or instated.	nvestigation, in my o	pinion, death occu			
	To th Vithir To th Xomp	Me	29b. Signature and title of certifier			29c. Licens	e number	2	9d. Date signed (A	fonth, Day, Year)
}			I Caul Do	mo	They	Xas HZ	6154		1120	109
		6	30. Name and address of person wh	o completed cause of	death (Item 23a) (Type	, Print)		A 1 1	1 ^	
		VA	Parel Davio	Miller	Do 691	NOLFA	teresty	- Cax	land 1	V( ()
	St	ate	31. Date filed (Month, Day, Year)	32. Regis	strar's Signature	1	,		7	1110
	Regist		.111 22	2009	un. A. A	marke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 23a per dr., g893,07/31/09dhb.

Certificate of Death

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Estelle Fletcher 2009 3:50 July /Medical 13, 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 1835 Clayton Drive Oxon Hill Prince George's If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 ☐ M 2 🖸 F 92 Director 223-18-5676 July 27, 1916 Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f sh dion Examiner must be notified 1√Yes 2 No Directo MD Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1835 Clayton Drive 20745 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. Specify: Black Completed by 3 ₩ Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 Domestic Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic er ပ္ John R. Baker Mary Constance Jackson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca Johnson-Daughter 1835 Clayton Drive, Oxon Hill, MDBaltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 ★Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Good Hope Cemetery 7-19-2009 Front Royal, VA 22. Name and Address of Facility Turner-Robertshaw 21. Signature of Funeral Service Deensee . W Tolin 1200 N. Shenandoah Avenue, Front Royal, VA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Renal Insufficiency** Immediate Cause (Final disease or condition resulting in death) **Physician** su munica /Medical Due to (or as a cons Cardiag Arrhythmia Examiner Sequentially list conditions, if any, but any to infine flat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit Hypertension Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Records, P.O. Box 68760 physician Heart Failure Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Division or Vital 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🌠 No 1 🗌 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 46285 Domw. 009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10905 Fort Washington Road, Fort Washington, MD Paul Fone, MD

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

		-	For State Registrar	State of	Marylar		artment of F		and Me	-	giene Reg. No.	0000	24551
			Decedent's Name (First, Middle	e, Last)						2. Date of De	ath		3. Time of Death
	ysicia /ledica	_	Fred Carl F	rischkorn			. <u>.</u>			JULY	Day 12	2009	20:27M
~~	amine		4a. Facility Name (If not institution				4b. City, Town, o		,	/	4c.	County of Death	•
			Teninsula Regional 5. Social Security Number		7. Age (In yrs.	last hirthday	If Under 1 Year	50//564 If Under 2	. /	8 Date of Bir	th	WICOM.	place (State or Foreign
Fun Dire			220-30-1742	1 <b>X</b> M 2 □ F	62	Yrs.	Months Days	Hours	Min.	8. Date of Bir (Month, Da 10/15/	1946	Cou	MD
70		-	Usual Residence of Decedent		10.0	- T							10d. Inside City Limits
faryla shov	ld at	.	10a. State 10b. County		10c. Ci	ty, Town or Lo Berli							1 ☐ Yes 2 🛣 No
the N	afficial distribution of the second	Director	MD Worc  10e. Street and Number	ester		berii	10f. Zip Code				10g. Citi:	zen of What Cou	ntry?
th with	STEE	a	10789 Cathell	Rd.			2183	l 1				USA	
Z I Z I 3-UU30 I within 72 hours after death with the Maryland giene. It than "natural", or items 23a or 28a-f show	ME THE	Funeral	11. Marital Status	12. Was Deced	ces?	.S. 13.	Was Decedent of H	lispanic Orig an, Mexican,	gin? (Spec	cify Yes or No lican, etc.)	)-	14. Race - Ameri Black, White,	can Indian, etc.
s afte	5	by Fi	1 ☐ Never Married 2 ☐XMarr 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	e		1 □Yes 2 <b>X</b> □No	Specify:					nite
5-0036 72 hours af natural", or	3		15. Deceden	t's Education		16a. Dece	dent's Usual Occup	ation			16b. Kii	nd of Business/Ir	ndustry
Kithin 7. Te.	Mad	Completed	(Specify only highes Elementary/Secondary (0-12)	st grade completed)  College (1-	4or 5+)	life.	kind of work done of NOT use retired	d)	of working	g			/D
S G G	2 L		47 Fabrus Nama / Final Adiable	4		Self	Employed		ula Manna	(First, Middle	L		on/Buildin
<b>□</b> ₽ ₽ ₽	6	m	17. Father's Name (First, Middle, Henry W. Frisch					Sarah			, maiden	Surname)	
arylar should be and Menta	иmati	٥.	19a. Informant's Name/Relations	-		19b. Mailir	ng Address (Street				er, City o	r Town, State, Zi	p Code)
and 2 steath an eatth an 127 is r	er tra	. 10	Katherine Hearn	e / daught	ter	37 S	toney Rur	n Rd.,	, Wili	mingto	n, D	E 19809	
Ore, jesta tof Hee if item	any injury or other traumatic once.		20a. Method of Disposition 1 ☐ Burial 2 🄀 Cremation	3 ☐ Bernoval from S	20b. I	Place of Dispo cemetery, crer	sition (Name of natory or other place	ce)	Da			ocation - City or To	
Dalling  Dermit. Pages Department of	Juny		4 □ Donation 5 □ Other (S	pecify)			lopen Cre					nkford,	
pall permit. Departr Importa	any ir		21. Signature of Fundral/Service	Licensee		- 1	2. Name and Addre					ral Home 21811	!
-			23a. Part 1. Enter the disease, or	complications that ca	used the deat								Approximate
Physic	ian		shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on va	ich line.	T. Cr	null (el	ll G	ma	lom	th		Interval Between Onset and Death
/Med	ical		resulting in death)	a. Due to (c	or as a consec	uence :	7000	. 00	Ü	- 1	CUI		11110
Exami			Sequentially list conditions,	b	with	Res	print	my		activ	re	-1:	
ited	usit.	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (c	or as a consec	quence of):	,	C					
execu n and	ial-tra	Examine	that initiated events resulting in death) Last	c Due to (c	or as a conseq	uence of):							
ficate be executed physician and	ne bur	dical		d									
ertifica ling pt	e as t	Med	IF FEMALE:	1									
Attending Physician: The law requires that the death certificate.  ector: After this certificate has been signed by the attending I	for us	hysician/Me	23b. Was decedent pregnant in the past 12 months?		ome of pregna irth 2☐ Feta ant at time of	aideath 3 [	Ectopic pregnanc Other (specify)	'y			2	23d. Date of deliv Month	very Day Year
the de	ched	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unkno		deam 5L	Other (specify) _						
s that	e deta	0	Part II. Other significant condition	ns contributing to dea	ath but not res	sulting in the u	nderlying cause giv	en in Part I.		23e. Did	tobacco u	se contribute to	the cause of death?
law requires t as been signe	q pinc									1 🗆	Yes 2[	□ No 3 □ Pro	bably Unknown
law re	2 sho	Completed								24a. Was	DSV	prior to co	opsy findings available ompletion of cause of
The The	, page	S CO								perfo 1 □ Yes	2. No	death? 1 □ Ye s	·
VII.dl siclan: 1 certifica	rector	<b>m</b>	25. Was case referred to medical examiner?	Hospital: A			ot 3 DOA Oth	or:		(Check only			
Physer this	eral di	Certification: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date o	f Injury	ER/Outpatier 28b. Time o		7		le 5 ☐ Resi 8d. Describe		6 ☐ Other (Spec y occurred	ify)
nding ath. r: Afte	e true	atio	Natural 5 Pending	9	n, Day, Year)	Injury		k? Yes 2□N			,	,	
r Atte	å :	titic	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	not be ined 28e. Place of building	of Injury - At h	ome, farm, str fy)	eet, factory, office		28	Bf. Location (			ral Route Number,
Dital o	lled if		00- 0- Will-	1									
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending	completely filled in	Medical	29a. Certifier  (Check only one)  Check only one)	ng Physician: To the I Examiner: On the ba and mann	sis of examina	owledge, deat ation and/or in	n occurred at the till vestigation, in my o	me, date an opinion, deat	id place, a th occurre	nd due to the d at the time,	cause(s) , date and	) and manner as d place, and due	stated. to the cause(s)
To the within To the	Idwoo	ğ	29b. Signature and little of certifier				29c. Licens	e number			29d. Dat	te signed (Month	, Day, Year)
			1100	amo			00	205	07		7/	13/09	
<b>.</b>			30. Name and address of person					02	C.	Δ.			
N 4+	,		31. Date filed (Month, Day, Year)	JR N SS 0 32. Re	i Vo	ature C	MRROL	17	31	91158	NRY	/ Y10L)	1
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State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ivia	-		te of Dea		Re	eg. No. 2009	24552
E	Physicia	an	1. Decedent's Name (First, Middle, Las ETHEL ELIZABETH		GAFFORD				JULY 16	Day Year	3. Time of Death <b>00:04</b> A M
3	/Medic Examin		4a. Facility Name (If not institution, give		ONLIGHT	4b. City	, Town, or Locat	tion of Death	3011 10	4c. County of Death	00.04 h
			SOUTHERN MARYLANI				LINTON er 1 Year   If Ur	nder 24 Hrs.	[ 0 D 1	PRINCE GEO	
	Funeral Director		367-26-3066	ex 7. Age □M 2 <b>X</b> F	e (In yrs. last birthe	Months			8. Date of Birth (Month, Day, APRIL 9	Year) 1922 GEOR	place (State or Foreign ntry) GIA
	rland IOW		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town of	r Location					10d. Inside City Limits
	e Man ta-f sh	ctor	MD PRINCE (	GEORGES		CLINTO	1				1 ▼Yes 2 No
	be filed within 72 hours after death with the Maryland that Hygiene.  Id other than "natural", or items 23a or 28a-f show event, the Medical Eventirer must be reaffied at	al Director	10e. Street and Number 9211 STUART LANE			10f. Z	20735		1	0g. Citizen of What Cou UNITED ST	
	tems terms	Funeral	11. Marital Status	12. Was Decedent B Armed Forces?	Ever in U.S.	13. Was Deci	edent of Hispani ecify Cuban, Me	c Origin? (Sp xican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White,	
920	urs afte	þ	1 ☐ Never Married 2 ☐ Married  3X Widowed 4 ☐ Divorced	1 ∐Yes 2 ∭∑N If Yes, Give Year or Dates:	10	1 □Yes	2 XNo Spe	ecify:		Specify: BL	ACK
21215-0036	72 hou	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. D	ecedent's Us Give kind of w	ual Occupation ork done during use retired)	most of work	ing	16b. Kind of Business/Ir	ndustry
121	within ene. than "	Jumo	Elementary/Secondary (0-12)	College (1-4or 5	+1	IGE. DO NOT	use retired)		I	FEDERAL GOV	ERNMENT
ם 2	0 7 5	Be Co	17. Father's Name (First, Middle, Last)				18. N	fother's Name		Maiden Surname)	
ylar	thould be nd Ments marked matic ev	T0 E	WILLIAM KILLEBREV	<b>I</b>			ALM	A ELIZ	ABETH DO	OWNS KILLEB	REW
Maryland	2 s ls ls		19a. Informant's Name/Relationship (T							; City or Town, State, Z VASHINGTON .	
	s 1 and of Health item 27 other to		20a. Method of Disposition	-	20b. Place of D				<del></del>	20c. Location - City or T	
Baltimore,	Pages ment of ant: If it		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			GE MEMO	ORIAL CE		23, 200	O9WALDORF,	MD
Ball	permit. Pages Department of Important: If it any Injury or o		21. Signature of Funeral Service LYDIA C. THORN		ON MO0583	17HORN 3439	and Address of F TON FUNI LIVINGST	ERAL HO ON ROA	OME, P.A.	AN HEAD, MD	20640
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that caused	the death. Do no	t enter the mo	ode of dying, suc	ch as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	.a	4 henric						Onset and Death
J.	Examiner			Due to (or as	consequence of	Ischer	Su				
	₽ #	ner	Sequentially list conditions, if any, reading to firm solute cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as:	n consupernou of	,	-(9				
_	xecute and I-trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of	):					<u> </u>
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89 >	ertifica ling ph e as th	Medi	IF FEMALE:								100
Box	attendin for use	Physician/N	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal death	3  Ectopic				23d. Date of deli Month	very Day Year
P. O.	at the de by the tached	hysic	1 □Yes 2 ☑No 9 □ Unknown	9 Unknown							
ds, F	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	þ	Part II. Other significant conditions of	ontributing to death bu	.17	he underlying	4	Part I.		bacco use contribute to es 2 ☑ No 3 ☐ Pro	the cause of death?
Records,	w request speed	Completed	Interhad oboth	whin		Ó			24a. Was a		opsy findings available
Ä		mo							autops perfori 1 □Yes	med? death?	ompletion of cause of 2 No
Vital	slcian: The la certificate ha irector, page 2	Be	25. Was case referred to medical examiner?	Hospital:			26. I	Place of Deat	h (Check onl on		
	Phys r this ral dir	5	1 Yes 2 ☑No  27. Manger of Death	28a. Date of Inju			28c. Injury at Work?	☐ Nursing Ho		ence 6 Other (Spec	eify)
0	Attending Physician: sr death. ector: After this certific by the funeral director, I	atior	1  Natural 5  Pending 2  Accident investigation	(Month, Da	y, Year)   Inj	ury M	Work? 1 □ Yes	2 □No			
Division of	il or Atte fter de Directo d in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc	ury - At home, farn c. (Specify)	n, street, facto	ry, office		28f. Location (S. City or Town	treet and Number or Ru n, State)	ral Route Number,
	To the Hospitall or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one) (Check only one)	nysician: To the best on the basis on the basis on the basis on the basis on and manner sta	f examination and	death occurre or investigation	ed at the time, da on, in my opinior	ate and place n, death occur	, and due to the orred at the time, o	cause(s) and manner as late and place, and due	stated. to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature appring of pertifier	wild Halfiller Sta		2	9c. License num	nber	2	29d. Date signed (Monti	ı, Day, Year)
			> K/Whine	- ho			D0055	120		Tuly 16 2	ילטו
(	RIL		30. Name and address of person who		eath (Item 23a) (T		12-	12-1	1	J	T)
	7) 4 Sta	te	31. Date filed (Month, Pay, Year)		<u>lm Wen</u> ar's Signature	4 58 7	nete 310_	WASHI	yours 2	eu3 L	
	Registr		3111 172	nno 1	4	1					

DHMH 17 Rev 1/2001

09-05580 John Paul Girolamo Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ July 16, 2009 2124 hrs **Medical Examiner** John Paul Girolamo 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Prince George's Hospital Center Cheverly 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 7. Age (in yrs. last birthday) 6 Sex 5. Social Security Number **Funeral** Foreign Days Hours Months Country) New York Director 12/31/1976 1 X M 2 32 067-60-7152 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County ű 1 Yes 2 X No s 23a or 28a-f show notified at once. Lusby MD Calvert death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20657 12955 Mills Creek Drive 13. Was Decedent of Hispanic Origin? ( Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12 Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 2 X No Yes Specify: White Yes 2 X No specify: Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after of
Department of Health and Mental Hygiene. Vec Give Year 4 X Divorce Widowed 3 nt: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner ۵ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Habitat for Humanity 4 Manager 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Paula Mae Denton Be John Joseph Girolamo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ဥ 12951 Mills Creek Drive, Lusby, MD 20657 Paula Mae Walker / Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 07/19/2009 Alexandria, Virginia Metropolitan Crematory Donation 5 Other Specify 10 22. Name and Address of Facility Rausch Funeral Home, P.A. 21/Signature of Funeral Service License P.O. Box 600, Lusby, MD 20657 23a. Part I. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. Death /Medical a. Multiple Injuries Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and or use as the burial - transit The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED Box 68760, 23d, Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Fetal death Live birth past 12 months Pregnant at time of death Other (Specify) 5 signed by the atte 1 Yes 2 No 9 Unknown a Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Records, P.O. Yes 2 No 3 Probably 4 V Unknown þ Completed 24b. Were autopsy findings available 24a. Was an has been s prior to completion of cause of autopsy death? performed? ✓ Yes ✓ Yes 2 Ac stospital or Attending Physician: The Thousafter death. 26.Place of Death (Check only one) 25. Was case referred to medica Be Other; Hospital: 1 Residence 6 Nursing Home 5 DOA Inpatient 2 V ER/Outpatient 3 1 V Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury Jul 16, 2009 28b. Time of Injury 27. Manner of Death Subject motorcyclist involved in motor vehicular Certification: 1957 hrs Yes 2 V No 1 Natura Pending accident 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be or Town, State)
NB Leonardtown Road at Homeland Drive, Hughsville, M 3 Suicide determined (Specify) Major Road / Highway Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ical and manner stated 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier **OCME** July 17, 2009 O.C.M.E. Name and address of person who con 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Theodore M. King, Jr., MD. istrar's Signature 31. Date filed (Month State Registrar

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene 1,24a per dr., g893,07/31/09dhb
Registrar Certificate of Death Rec. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 12:53 AM Month Physician July 14 2009 Elmer Hammen, Junior HOWARD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 102 Susquehanna Court Harford Havre de Grace Sex 1X M 2□ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 10, 13, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 65 Pennsylvania Director 188 32 8212 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show in than "natural", or items 23a or 28a-f show 1 XYes 2 No Maryland Harford Havre de Grace Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21078 102 Susquehanna Court U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 1960-63 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shift supervisor Chemical 12 h and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f Mental I permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Howard Elmer Hammen, Senior Edna Mae Jurkovitz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Hammen (wife) 02 Susquehanna Crt, Havre de Grace 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Wesleyan Chpl. Cem. 7/18/09 Havre de Grace 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Jun la Tarring-Cargo Funeral Home, P.A 333 S. Parke St, Aberdeen, MD ronles Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, Immediate Cause (Final **Physician** Hetaslalie disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of) burial-transit and Due to (or as a consequence of): Box 68760. attending physician certificate be Physician/Medical the as IF FEMALE: nse If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ó Month Day Year 5 Other (specify) 0 the ☐Yes 2☐No detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2X No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2NO No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier f certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and itle of certifier 29c. License number

Registrar

State

3

So Union Are, House de Grace, MO 21078

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

3 1 2009

700

32. Registrar's Signature

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		Registrar  1. Decedent's Name (First, Middle, Last)		Cei	lincale	OIL	Calli	2. Da	ate of Deatl	g. No.		3. Time of D	eath
Physic		Gertrude Holbrook							onth 1 V	9 20	Year	1456	М
/Med Exam		4a. Facility Name (If not institution, give street and	number)		4b. City, To	own, or l	ocation of		<u> </u>	4c. County of		1750	
_ Adiii	.3	Anne Arundel Medica	1 Center		Ann	ano	lis			Anne	Aru	nde1	
Funera		Social Security Number     6. Sex	7. Age (In yrs. last birt		If Under 1			4 Hrs. 8. Da	ate of Birth		9. Birthpla Countr	ice (State or F	
Directo		219-30-2925 1DM X	75	Yrs.				Sep	t 13	1933	Mar	yland	
and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	n or Lo	cation						100	d. Inside City	Limits
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sms (	Funerai	11. Marital Status 12. Was D	ecedent Ever in U.S. Forces?	13. \				in? (Specify Y Puerto Rican	es or No-	14. Race	· America		
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Ments Ments wrked	To	Archie Blunt					Ugi	e Uno	btai	nable			
ire, Maryland ZIZID-UU30  1 and 2 should be filed within 72 hours atter death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Madical Examinal must be notified at		19a. Informant's Name/Relationship (Type, Print)	19b.	. Mailir	ng Address (	Street a	nd Number	r or Rural Rou	te Number,	City or Town, S	State, Zip C	lode)	
By R		Clyde Hill(Nephew)	20b. Place of		York		n Rd	Date		lis, Mo			
in it it		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ Removal from the second sec	om State cemeter	ry, cren	natory or oth	er place					•		
Destruit. Pages of Deportment of Himportant: If its any njury or of page.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funerat Service Licensee	Fowle							Annapo ary, P		, Md.	
Dep		21. Signature of Puneral Service Licensee	i-lina							-		1 _	
#1		23a. Part1. Enter the disease, or complications the	et caused the death. Do n							, Md. 2		Approximate	
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Physician /Medica	_	disease or condition resulting in death)	to (or as a consequence)	90:	myo	ec.	LOW	101	DA	12.0%		Im	
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VISION Attending or death. rector: After by the fune	fical	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Pl	ace of Injury - At home, fa	ırm, str				28f. L		reet and Numbe	or or Rurai	Route Numb	er,
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DIVISION OF VITAL KEY TO the Hospitel or Attending Physicien: The taw within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	aic	29a. Certifier 1 Certifying Physician: To	the best of my knowledge	e, deatl	h occurred at	t the time	e, date and	d place, and d	lue to the ca	ause(s) and mar	nner as sta	ited.	
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		1 Cuns 10 B	hely		10	000	2010	3		: 119	10	)	
CMA	-	30. Name and address of person who completed of	ause of death (Item 23a)	(Туво	Print)	1	N	247	OFE	arll Ph	illi	ps	
34.0	toto	31. Date filed (Month, Day, Year) JUL 15 2009	Registrar's Signature	0	in				- 1				
S Regis	tate trar	JUL 15 2009	Beneva B.	1	back								

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day July 21, 2009 1940 hrs Edward Hunt, III Medical Examiner Robert 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Montgomery Silver Spring Holy Cross Hospital 9. Birthplace (State or If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Coun**Marvland** Months Days Hours 06/25/1982 Director 1 X M 2 F 27 Yrs 219-59-7269 Usual Residence of Decedent 10d, Inside City Limits 10c, City, Town or Location 10a State Inh County Yes 2 X No 28a-f show Huntingtown Calvert MD death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20639 Wildflower Lane 2410 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 X Married 2 X No Yes white Yes 2 X No specify: Pages 1 and 2 should be filed within 72 hours after reent of Health and Mental Hygiene.
ant: If tiera 27 is marked other than "natural", o oner traumatic event, the "Medical Examiner. If Yes, Give Yea Specify: Divorced Widowed ģ 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 construction carpenter 9 18.Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last) Diege1 Bridget Be Edward Hunt, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 2410 Wildflower Ln., Huntingtown, MD 20639 Lauren E. Hunt, wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 X Cremation Removal from State Metropolitan Crematory 07/25/09 Alexandria, VA Department o Donation 5 Other Specify Rausch Funeral Home, P.A. 22. Name and Address of Facility Signature of Funeral Service 8325 Mt. Harmony Lane, Owings, MD 20736 War plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a. Part / Enter the disease, or confailure. List only one cause on **Physician** Between Onset and Medical Death a Chronic alcoholism with complications Immediate Cause (Final disease \*xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. and Physician/Medical X UNPENDED X AMENDED e attending physician for use as the burial as noted, 23a, PII, 27, perm, E g897 11/17/09 **T**T Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If ves, outcome of pregnancy 3b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 V Unknown Concentric left ventricular hypertrophy Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? this certificate has performed? 2 No ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 🗸 Inpatient Other<sub>4</sub> 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 🗸 Yes ٩ No After 1 28a. Date of Injury (Month, Day, Year 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification: 1 X Natural Yes 2 No within 24 hours after death. To the Funeral Director: filled in by the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number OCME July 23, 2009 O.C.M.E. JA 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD. 32. Registrar's Signature State 22 2000

Registrar

State

31. Date filed (Month, Day, Year) JUL 2 0 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 15, 2009 3:33 P. M Jr. Fred William Holzberger, July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examine Montgomery Rockville Shady Grove Adventist Hospital If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 X M 2 □ F 577-12-3486 89 **Director** Dec. 8, 1919 Washington, DC Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 28a-f show d other than "natural", or items 23a or 28a-f show event, the Idealical Examiner must be notified at 1K Yes 2 □ No Director Rockville Maryland | Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20850 United States 14 Pitt Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ⊠Yes 2 □ No 1945— If Yes, Give Year or Dates: 1946 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: by 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withit Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other trailmosts. Naval Air System Elementary/Secondary (0-12) College (1-4or 5+) 12 Systems Analyst Command 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Fred William Holzberger, Sr. Elizabeth Burwinkle 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor H. Holzberger/Wife 14 Pitt Court, Rockville, Maryland 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 7/20/2009 Silver Spring, MD. 0 22. Name and Address of Facility DeVol Funeral Home dure of Funeral Service Licensee 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Failure Hours /Medical Due to (or as a consequence of): Examiner Days Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): certificate be executed and burial-tra Due to (or as a consequence of) Box 68760. the attending physician hed for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? The law requires that the death 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the 1 ☐Yes 2 ☐ No P.0. 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 1 □Yes 2 ☒ No certificate 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? he Hospital or Attending P in 24 hours after death.
he Funeral Director: After t pletely filled in by the funera 28d. Describe how injury occurred After 1 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific July 15, 2009 15+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D 9901 Medical Center Drive, Rockville, Maryland 20850 State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	1 - State Registrar	Certificate of I	Death	F	Reg. No 2 0 0	9 24559
	Dhysisia		1. Decedent's Name (First, Middle, Last)			2. Date of Dea Month		3. Time of Death
	Physicia /Medic		Mary H. Jacobs			Ju1y		9:50 A <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street and number)		Location of Death		4c. County of	
			Spa Creek Center  5. Social Security Number 6. Sex 7. Age (In yrs. last birt)	Annapo	Lis I If Under 24 Hrs.	8. Date of Birt	h 9	Arundel  Birthplace (State or Foreign
	Funeral Director		1□M 2√2F 98	Yrs. Months Days	Hours Min.	(Month, Da	y, Year)	Country)  Texas
			267-30-3700 Usual Residence of Decedent				/ 1 / 1 1	
	rylan how	_	10a. State 10b. County 10c. City, Town					10d. Inside City Limits 1 ▼Yes 2 □ No
	Ba-f s	Director	Maryland Anne Arundel Annap				10 000 1110	
	or 2	Dire	10e. Street and Number	10f. Zip Code			10g. Citizen of Wha	at Country?
	s 23a	era	35 Milkshake Lane	21403		pecify Ves or No.	USA 14 Bace	American Indian,
	item item	Funeral	11. Marital Status  1 □ Never Married 2 □ Married  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No	13. Was Decedent of H If Yes, specify Cuba		Rican, etc.)	Black,	White, etc.
036	al", or	ξ	If Yes, Give A 3 Widowed 4 □ Divorced Year or Dates:	1 AYes 2 No	Specify: Mex	xican	Specify:	White
21215-0036	within 72 hours after death with the Maryland tene. than "natural", or items 23a or 28a-f show he Modical Examiner must be notified at	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occup (Give kind of work done	eation during most of work	kina I	16b. Kind of Busin	ness/Industry
21	ithin 7 ne. <b>nan "</b> i	mple	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired	Homemal		Own Hor	me
2	led w tygiel her th	Ö	12 17, Father's Name (First, Middle, Last)				Maiden Surname)	
anc	ntal Hed or	Be				a Garza		
Z	hould nd Me mark matic	욘	Pedro Hinojosa  19a. Informant's Name/Relationship (Type. Print)  19b.	. Mailing Address (Street			er, City or Town, St	tate, Zip Code)
Maryland	nd 2 s ulth ar 27 ls r trau			4944 Compass				
re,	s 1 ar		20a. Method of Disposition 20b. Place of cemeter	f Disposition (Name of ry, crematory or other place	ce)	Date	20c. Location - Ci	-
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evancines must be published at once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	more Cremato	ry 7/1	4/2009	Baltimo	re, MD
alti	permit. Departn Importa any Inju		21. Signature of Funeral Service Licensee	22. Name and Addre	0		•	neral Home, Inc
8	8 4 5 5 6 6		Myelin T. Klobeet					1is, MD 21401
			23a. Part 1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.	. 1			rrest,	Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	Alzhein	er', De	men		dyr
	Examiner		Due to (or as a consequence of	of):				
		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of	of):				
	tuted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Universitying Cause (Disease or injury that initiated events					- 1
o,	e exectan an an Irial-tr		resulting in death) Last	of):				
68760,	rificate be executed ng physician and as the burial-transit	Medical	d					
	ertific ding p	Mec	IF FEMALE: 23c. If yes, outcome of pregnancy				and Date	of delivery
Вох	law requires that the death cer as been signed by the attendir 2 should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months?  1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 Ectopic pregnand 5 Other (specify)	су		23d. Date Mont	
o.	y the	ysic	1 Yes 2 No 9 Unknown	o E o mon (oposiny)				
٠ <u>.</u>	w requires that the designed by the should be detached	by Pr	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause giv	ven in Part I.	23e. Did 1	tobacco use contrib	oute to the cause of death?
rds	quires en sig uld be					1 🗆	Yes 2/20No 3	B ☐ Probably 4 ☐ Unknown
Records,	law recast bee	Completed				24a. Was		ere autopsy findings available for to completion of cause of
æ	The law ate has page 2 s	mo:					rmed? de	eath? ⊒Yes 2 □ No
Vital	strifica ctor, 1	Be C	25. Was case referred to medical examiner?		26. Place of Dea	ath (Check only	one)	
of V	Physiclan: r this certific ral director, i		1   Yes 2   Hospital: 1   Inpatient 2   ER/Ou	utpatient 3 DOA			idence 6 Other	
ň	ling P	ion:	n Natural 5 ☐ Pending (Month, Day, Year)	Time of 28c. Inju Wo 1	nryat rk? ]Yes 2 ∐No	28d. Describe	how injury occurred	u
isic	Attending r death. ector: Afte by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, fa		les 2 Livo	28f. Location (	Street and Number	r or Rural Route Number,
Division	after Direct	Certification: To	4 Homicide determined building, etc. (Specify)			City or To	wn, State)	
	Hospital or 24 hours afte Funeral Dir tely filled in		29a. Certifier Check only (Check only (Che	e, death occurred at the	time, date and plac	e, and due to the	cause(s) and mar	nner as stated.
	To the Hospital or Attending Physiclan: The I within 24 hours after death.  To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Medical	one) and manner stated.		*****			
_	Vitto To	2	29b. Signature and title of certifier	29c. Licen	21 1.21		7/17/	(Month, Day, Year)
			Jog Warm	(Time Brint)	00 406	)	11121	0 00/
1	412		30. Name and address of person who completed cause of death (Item 23a)	a timel!	ine (	feste.	CIM,	21619
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	4.41				
	Registr	O.F	1111 16 2009 Dune D.	1 and				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Per State of Maryland / Department of Health and Mental Hygiene PHY AND Health Cartificate of Death Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2009 July 11, **Physician** 4:35 Рм Marguerite Cecile Lutz /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Annapolis 6 Somerset Ct. If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5/12/1911 Birthplace (State or Foreign Country)
 N 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days 1 □ M 2 1 F Hours New York 073-22-6318 98 Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County Anne Arundel Annapolis Maryland 1 Yes 2 □ No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21403 11 Ashford Ct. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2**∑N**No 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 □Yes 2 X No Specify: Completed by Specify: White 37□ Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NY State Government Civilian Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Delia Maher James McKenna မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 6 Somerset Ct., Annapolis, MD 21403 Peggyann DiConsiglio 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/15/2009 St. Teresa Cemetery Summit, NJ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home, Inc 21. Signature of Funeral Service Licenses Museli 147 Duke of Gloucester St., Annapolis, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) evelorovascular disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Year Month 5 ☐ Other (specify) 9 Unknown 9 Unknown

**Physician** /Medical Examiner

for use as the burial-transi

After this certificate has been signed by the funeral director, page 2 should be detached

þ

Completed

Be

Certification: To

Medical

3 ☐ Suicide

29a. Certifier

4 Homicide

Physician: The law requires that the death certificate be executed

Box 68760,

P.O.

of Vital Records,

Division Hospital or Attending

death.

within 24 hours after deatl To the Funeral Director:

filled in by

completely

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

other traumatic event, the Wedical Examiner must be notified at

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tob	acco u	se con	tribute to the cau	use of death?
1 ☐ Ye	s 2	No	3 ☐ Probably	4 🗌 Unknown
24a. Was ar autopsy	1	24b.	Were autopsy fi prior to complet	ndings available ion of cause of

death? 1 □ Yes

2 No

autopsy performed Yes 2

26. Place of Dea	th (C	neck only one)	
her: 4 🗆 Nursing H	ome	5 Residence 6 X Other	(Specify) Daughters
ury at ork?	28d.	Describe how injury occurred	Residence

25. Was case referred to medical Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 1 Natural 2 Accident 5 Pending investigation

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) and manner stated. 29b. Signature and fifte of certifier

6 Could not be determined

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

estgate Rd. Annapolis, Md. 21401 Selonick, MU 900 Stuart 31. Date filed (Month,

State Registrar

32. Registrar's Signature Year) **JUL 16** 



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year SOAM **Physician** 2009 Walter Reynolds Layton, Sr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Easton Hospital at Memorial 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) June 28,1928 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Sex 1 X M 2 ☐ F **Funeral** Days Hours 81 214-30-8255 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "Notical Expriment must be notified at 1 XYes 2 □ No Director Maryland Dorchester Hurlock 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with USA 21643 400 N. Main Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ②Yes 2 □ No Years If Yes, Give Year or Dates: Unknown Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify. Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "na 2121 College (1-4or 5+) Elementary/Secondary (0-12) Panel Board Operator Manufacturing 11 18. Mother's Name (First, Middle, Maiden Surname) land 17. Father's Name (First, Middle, Last) Be Bessie Neal William Haddaway Layton မ Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau once. Pages 1 and 2 112 Dogwood Drive, Hurlock, Maryland 21643 Cynthia Eberspacher/Daughter Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Unity Washington Cem. 7/20/2009 Hurlock, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Zeller Funeral Home, P. O. Box 207
106 Main Street, East New Market, 21. Signature of Fyneral Service MD 21631 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lune Cancer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed Due to (or as a consequence of): physician a s the burial-t Box 68760, Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 1 cate has been signed by the page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 WYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) 25. Was case referred to medical funeral director, Be Other: 4 \( \text{Nursing Home} \) \( \frac{5}{\text{ Residence}} \) \( 6 \) \( \text{Other (Specify)} \) 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No spital or Attendin nours after death. neral Director: Af y filled in by the fur investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Umedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 7-17-09 D0059487 Hue Bother 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year) JUL 20

John Botsis, 219 S. Washington Street, Easton, Maryland 21601 32. Begistrar's Signature

Physic	an	1 Stete Amend Item Registrar  1. Decedent's Name (First, Middle, Last,	Anna Chr	istine McC	uncate or L	2007	2. Date of Death	g. No.	3. Time of Death
/Medi				a McCullough	45 City Town on	Lanction of Dooth	July	4c. County of Deeth	
Examir	ier	4a. Facility Name (If not institution, give Allegany Count		d Rehab Center		Location of Death  Cumber	rland		egany
Funeral Director		5. Social Security Number 6. Sec		93 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, November 2	9. Birth (26, 1915) 9. Birth	place (State or Foreign ftry) est Virginia
> 55		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	veation				10d. Inside City Limits
shor	ō		gany	Too. Only, Town of Lo		Cumberland			1 ☐ Yes 2 No
r 28a-	rect	10e. Street and Number	S7		10f. Zip Code		10	g. Citizen of What Cou	ntry?
23a o	a	730 Fur	nace Street			21502		US	A
Department of results and Mental Hyglene. Importent: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show my injury or other traumatic event, the Medical Examination and anone.  Once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ▼ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces?  1  Yes 2 11 Yes, Give Year or Dates:	10	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Spin, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify:	
aturel	led t	15. Decedent's Edu	ucation	16a. Dece	dent's Usual Occupa	ation	. 1	6b. Kind of Business/Ir	
Man on	Completed	(Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1-4or 5	life.	kind of work done of DO NOT use retired	during most of work	ing		
other th	Con	10	0	·	Но	omemaker	(F) 1 AC 1 (1) 14		me
even	Be	17. Father's Name (First, Middle, Last)	William Duige			18. Mother's Name		phine Gibbs	
and Mental is marked c aumatic eve	2	19a. Informant's Name/Relationship (7)	William Price		ng Address (Street a	and Number or Rura		City or Town, State, Zi	p Code)
m 27 is ner trau		Daniel McCullo			1109	Allison Drive	, Rockville,	Maryland, 208	51
f Item		20a. Method of Disposition  1 XBurial 2 Cremation 3 F	Damassal from State	20b. Place of Dispo cemetery, cre	sition (Name of matory or other plac		Date 2	Oc. Location - City or T	own, State
ent: If	Ш	'4 □Donation 5 □ Other (Specify)		Hillcre	st Memorial	Park Ju	ıly 30, 2009	Cumberland	l, Maryland
Importent: If I any injury or one		21. Signature of Funeral Service Licens	Wilhe	2m	2. Name and Addres	ss of Facility ast Main Stre		n-McKenzie Fu aconing, MD 2	
Medical and physician and the burial-transit	dical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as	a consequence of): a consequence of): a consequence of):	SCILI				
ied by the attending pl detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli	very Day Year
sigr d be	by	Part II. Other significant conditions co	entributing to death b	ut not resulting in the u	inderlying cause give	en in Part I.		acco use contribute to s 2 ☐ No 3 ☐ Pro	
been	ompleted						24a. Was ar autopsy perform 1 Yes 2	/ prior to c	copsy findings available ompletion of cause of
has Je 2	C	25. Was case referred to medical examinar?					h (Check only one	9)	
ate has page 2	00	1 Yes 2 No	Hospital: 1 ☐ Inpatie			4 Nursing Ho	ome 5 Resider	nce 6 Other (Spec	ify)
is certificate has director, page 2	To B	OT Manager of Death	28a. Date of Inju	y Year) 280. Time o	Wor	yat k? Yes 2□No	200. Describe no	w injury occurred	
iter this certificate has neral director, page 2	2	27. Manner of Death  1 Natural 5 Pending							
ctor: After this certificate has y the funeral director, page 2	2			ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (Str City or Town	eet and Number or Ru , State)	ral Route Number,
death. <b>ctor:</b> After this certificate has y the funeral director, page 2	Certification; To	1 Natural 5 Pending Investigation 3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Inj building, et	c. (Specify)  of my knowledge, deat f examination and/or in	h occurred at the tin	ne, date and place, pinion, death occur	City or Town	reet and Number or Ru , State) suse(s) and manner as ate and place, and due	stated.
death. <b>ctor:</b> After this certificate has y the funeral director, page 2	2	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifler (Check only (Check o	28e. Place of Inj building, et vsicien: To the best iner: On the basis o	c. (Specify)  of my knowledge, deat f examination and/or in	h occurred at the tin	pinion, death occur	City or Town	use(s) and manner as	stated. to the cause(s)
iter this certificate has neral director, page 2	Certification; To	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifler (Check only one)  5 Pending investigation 6 Could not be determined	28e. Place of Inj building, et vsicien: To the best iner: On the basis o	c. (Specify)  of my knowledge, deat f examination and/or in	th occurred at the tin	pinion, death occur	City or Town	, State) use(s) and manner as ate and place, and due	stated. to the cause(s)

34

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2009 July Daniel Kempster Morga1 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner North Beach Calvert 7th Street If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 ☑ M 2 ☐ F 577-20-7674 86 01/08/1923 Washington, DC Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it with Modical Examinational portified an once. 1 ☐ Yes 2 No Director Calvert North Beach 10g. Citizen of What Country? 10e, Street and Number U.S.A. 3712 7th Street 20714 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever In U.S. Armed Forces? 11. Marital Status 1 Myes 2 No If **Ye**s, Give Year or Dates: 1942–45 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: white þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) automotive dealer automobile mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hunter Hilda ပ္ John William Morgal, Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Margaret Henderson, niece 35899 Sycamore Court, Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 Cremation 3 — Removal from State Resurrection Cemetery 07/22/2009 Clinton, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Funeral Service Licensee Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the die se, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fillule. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Firm disease or condition resulting in death) RENAL FAILURE Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine g physician and s the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an e has t autopsy performed?

1 Yes 2 No certificate h rector, p∈ge 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fr 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5+1 Peter L. Wisniewski, M.D. 110 Hospital Rd., Prince Frederick, MD 20678 of filed (Month, Day, Year) 32. Registray's Signature 31. Date filed (Month, Day, Year)

Registrar

20 2009

			_ For	State of Maryland	d / Depa	artment of H	Health and I	Mental Hy	giene		-1 :- 61
			1 - State Registrar		Ce	rtificate of	Death		Reg. No	009	24564
	Physicia	an	Decedent's Name (First, Middle, La	7.1.3.1				2. Date of Dea Month	ath Day	Year	3. Time of Death
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ы	Director		232-22-8218	1 <b>X</b> 1M 2□ F 90	) Yrs.	Months Days	Hours Min.	Octobe:	r 28,		West Virgini
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	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 Is marke any injury or other traumatic once.		21. Signature of Funetal Services ice	nsee			ess of Facility Ne				
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/IS	I or Attend after death Director: 3	ifica	3 ☐ Suicide 6 ☐ Could not b	28e. Place of Injury - At ho		reet, factory, office		28f. Location (	Street and	d Number or Ru	ural Route Number,
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification properties of the funeral director, to completely filled in by the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, the funeral director, the funeral director, the funeral director, the funeral director of the funeral director.	Medical	29a. Certifier (Check only one)  Certifying P  2 Medical Exa	hysiclan: To the best of my know miner: On the basis of examinat and manner stated.	viedge, dea ion and/or i	th occurred at the nvestigation, in my	time, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) date and	and manner as place, and due	s stated. to the cause(s)
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State Registrar Pranie Miller Do 31. Date filed (Month, Day, Year) JUL 21 2009

09-05576 **Douglas Newgent** Physician/ Medical Examiner Funeral Director in, 23a or 28a-f show notified at once. Director Funeral must be "natural", Examiner 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Registrar 2. Date of Death Time of Death Decedent's Name (First, Middle,Last) Month Day July 16, 2009 1718 hrs Douglas Barry Newgent c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Route 3 & I-97 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. Date of Birth (MM/DD/YYYY 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Foreign Cheverly, MD Hours Months Davs April 1, 1966 217-04-2934 1 X M 43 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 X No Davidsonville Maryland Anne Arundel Pages 1 and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygiene. 10g. Citizen of What Country' 10e, Street and Number 21035 USA 3566 Patuxent River Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black. 12. Was Decedent Ever in U.S. 11 Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 Married 2 X No Yes Specify: White Yes 2 X No specify: If Yes, Give Year 4 X Divorced Widowed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) narked other than " 21215-0036 Private Auto Shop Auto Mechanic 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Louise Kathleen Bickerton Barry R. Newgent Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Baltimore, MD 3566 Patuxent River Road, Davidsonville, MD 21035 Barry R. Newgent / Father t: If item 2 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Removal from State Cremation 1 X Burial 2 7/22/2009 Brentwood, Maryland Important: injury or oth Fort Lincoln Cemetery Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A. Hyattsville, as Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line Death Medical a. Multiple Injuries Immediate Cause (Final disease amine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and The law requires that the death certificate be executed Physician/Medical tending physician a UNPENDED AMENDED Box 68760. 23d. Date of delivery 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the Month Day 3 Ectopic pregnancy Fetal death Live birth 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown s been signed by the att should be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. P.O. Part II. Other significant conditions ò Yes 2 No 3 Probably 4 V Unknown Records, Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy certificate has performed? death? page 2 1 V Yes ✓ Yes 2 26.Place of Death (Check only one 25. Was case referred to medica the Hospital or Attending Physician: Division of Vital uneral director, Be examiner? Hospital: 1 Residence 6 V Other: Scene Nursing Home 5 ER/Outpatient 3 DOA Inpatient 2 this ပ 1 V Yes 28d. Describe how injury occurred 28a. Date of Injury Jul 16, 2009 28c. Injury at Work? 28b. Time of Injury After 27. Manner of Death Subject driver of vehicle involved in vehicular Certification: 1658 hrs spital or c.
44 hours after deau.
• ral Director: A 1 Natural Yes 2 ✔ No Pending accident 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State)
Route 3 & I-97, Crofton, MD determined 24 hours a (Specify) Highway Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the I and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29h. Signature and title of certifie July 17, 2009 O.C.M.E. OCME 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Theodore M. King, Jr., MD. 32. Registra 31. Date filed (Month State Registra

DHMH 17 Rev 1/2001 **OCME 2006** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Ju1y 2009 РМ 01:15 Anna Simone Oliva /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 306 Bay View Drive Edgewater 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months Hours 1 □ M 2 F Days 09/12/1929 79 Washington,D.C. 577-36-3314 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 28a-f show ed other than "natural", or items 23a or 28a-f shov event, the Medical Examinar must be redified at 1 ☐ Yes 2 XNo Director Maryland Anne Arundel Edgewater 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 306 Bay View Drive 21037 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🗓 No Specify White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker and Mental Hygic is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill fealth and Mental H Be Nellie Elizabeth Parma Dominic Simone 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert H. Oliva/Husband 306 Bay View Drive, Edgewater, Maryland 21037 Department of Healt Important: If Item 2 any injury or other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) Maryland Veterans Cemetery 07/20/2009 | Crownsville, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home Mela 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Jarran /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran and Due to (or as a consequence of) P.O. Box 68760, physiciar pe Physician/Medical as the the attending IF FEMALE: nse ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🗆 Ectopic pregnancy for Month in the past 12 Year signed by the at 5 Other (specify) ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown s peen s Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🔽 No Attending Physician: 25. Was case referred to medical examiner? v 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Pasidence 6 Other (Specify) 1 Yes 2 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 14 Natural 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Rysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the control of the control 29a, Certifier Medical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ce H56281 July 15, 2009

IPW

State Registrar 30. Name and address of pers

Timothy Paul F

31. Date filed (Month, Day, Yea . Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

3168 Braverton Street,

n who

Suite 330, Edgewater, MD 21037

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) ( Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) CLA Patricia Ann Horan Olsen **Physician** 1612 Olsen 5 H. tricia /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner RIDOT Hospi -mori 9. Birthplace (State or Fore 8. Date of Birth (Month, Day, Year) (State or Foreign 5. Social Security Number Age (In yrs. last birthday) **Funeral** Months Days Hours 1□ M 2▼F -42-923 03 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, II. Mydical Expriner must be notified an once. 1 ☐ Yes 2 No Director rassonvi tinne 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21638 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White Specify: ģ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired).

Office Manao Elementary/Secondary (0-12) College (1-4or 5+) Mother's Name (First, Middle, Maiden Surname) 18. 17. Father's Name (First, Middle, Last) Be Brose Horan ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 remation 4 Donation 5 Other (5 Silver Spring, M 3 Removal from State 07 20 5/ Other (Specify) 21. Signature of Funeral a BIND 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approxidate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 70 **Physician** ! /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 9 Unknown 9 ☐ Unknowr 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient Medical Certification: To 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signat 37064 65 30. Name and address of person who completed sause of death (Item 23a) (Type, Print) leh-Se-Carin 1 32. Registrar's Signature State

Registrar

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of	Marylan		rtment of F tificate of		and Men		ene2 0 0 9	24568		
	Dhusisi		1. Decedent's Name (First, Middle, Last)	ime (First, Middle, Last)						Date of Death Month	Day Year	3. Time of Death		
Physician /Medical John Maurice Pannell							uly 21	2009	6:15 a <sup>M</sup>					
7	Examir	er	4a. Facility Name (If not institution, give s 58 Castel Road	street and number)				City, Town, or Location of Death Oakland			4c. County of Death  Garrett			
	Funeral Director		5. Social Security Number 6. Sex	M 2□ F	. Age <i>(I</i> n <i>yr</i> s. :	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. 0 Min. 2	Date of Birth Month, Day, 15/54	(ear) 9. Birth	nplace (State or Foreign untry)		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Parical Examination and injury or other traumatic event, the Parical Examination of the page.	or	Usual Residence of Decedent  10a. State 10b. County  MD. Garrett			y, Town or Local	cation					10d. Inside City Limits 1 ☐ Yes 2 ☑ No		
e, Marylan		<b>Funeral Director</b>	10e. Street and Number 58 Castel Rd.		0.0	aktand	10f. Zip Code 21550	)		10	g. Citizen of What Cou	untry?		
		To Be Completed by Funera	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 ∐Yes 2 If Yes, Give Year or Date	es? L <del>i</del> No	1	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 No	lispanic Ori an, M <i>e</i> xicar <i>Sp</i> ec <i>ify:</i>	n, Puerto Rica	Yes or No- n, etc.)	14. Race - Amer Black, White Specify: Wh			
			15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation		(Give life. L	lent's Usual Occup kind of work done OO NOT use retired	during mos d)	t of working		6b. Kind of Business/li	·		
			17. Father's Name (First, Middle, Last) Hasque Banner Par	mell		50	one Maso	18. Mothe	·		aiden Surname) Stallard			
			19a. Informant's Name/Relationship (Ty) Etta Mae Pannell			1	g Address <i>(Street</i> Castel Rd	and Numb		ute Number,	City or Town, State, Z	ip Code)		
			20a. Method of Disposition  1⊠ Burial 2 □ Cremation 3 □ R  4□ Donation 5 □ Other (Specify)		ate c	emetery, cren	sition (Name of patory or other place)	ce)	Date	20	Oc. Location - City or T			
Baltii		Ì	21. Signature of Funeral Service License		k	22 I	Name and Addre David A.	ss of Facilit Burdo	ty _					
A. Park	Ician: The law requires that the death certificate be executed with a standing physician and incidence of the standing physici		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximately Con								Approximate Interval Between Onset and Death			
		L	resulting in death)  Sequentially list conditions.	_ (	Due to (or as a consequence of):							Yeur		
		dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	To	PMILO ras a consequ	use						Years		
O. Box 68		Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ∐Yes 2 □ No 9 □ Unknown		th 2 ☐ Feta Int at time of c	Ideath 3□	] Ectopic pregnanc ] Other <i>(specify)</i> _	у			23d. Date of deli	ivery Day Year		
rds, P.		þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							the cause of death? obably 4 ☐ Unknown				
Vital Records,		Completed									prior to death?  No 1 □ Yes	topsy findings available completion of cause of		
Ξ		o Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA			Oth	26. Place of Death (Chec		1	1			
Division of	Hospital or Attending 4 hours after death. Funeral Director: After tely filled in by the funer	$\vdash$	27. Manner of Death 1 Manual 5 Pending 2 Accident investigation	28a. Date of		28b. Time of Injury	28c. Inju	ry at	28d.		☐ Residence 6 ☐ Other (Specify) scribe how injury occurred			
Divisi		Certification:	3 Suicide 6 Could not be determined	f Injury - At ho , etc. <i>(Specif</i>	ome, farm, stre y)	e, farm, street, factory, office  28f. Location (Street and Number or Rural Route Num City or Town, State)					ral Route Number,			
		Medical C	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	To the within 2 To the comple	Me	29b. Signature and title of certifier	The			29c. Licens		4709		d. Date signed (Month	n, Day, Year)		
	5	2	30. Name and address of person who co	mpleted cause	of death (Iten	n 23a) (Type, I					MDS	1550		
	Sta Registr	_	31. Date filed (Month, Day, Year)		gistrar's Signa		Med	- 1110			11.0 V			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Month Day 14 2009 10:08 A M **Physician** July PARKER ANGELINA Ρ. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville 6001 Muncaster Mill Road-Casey House If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Months Hours Min. 1 □ M 2**K** F 79 Washington, D.C. 1930 577-38-5493 May 10 Director Usual Residence of Decedent 10d. Inside City Limits 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evention in ust be notified at 10a. State 1 □Yes 2 No Director Wheaton Montgomery Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20902 United States 11606 Channing Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: \$ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event. The Me filed within College (1-4or 5+) Elementary/Secondary (0-12) Government Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Chaconas Christ Pappas 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9612 Bush Hill Terrace, Gaithersburg, Md. 20882 Morris Lee Parker, Jr. / Son Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Rockville, Maryland 7/17/09 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Cemetery 22. Name and Address of Facility Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, 21. Signature of Funeral Service Licensee Md. 20882 0 200 P. O. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Clostridium difficile colitis **Physician** /Medical Due to (or as a consequence of) **Examiner** Transaminitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) attending physician Box 68760 Physician/Medical as the b nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) signed by the a P.0. 9 Dunknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ Diabetes mellitus 1 Tyes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Hypertension 24a. Was an autopsy performed? Yes 2 No has certificate 1 ☐ Yes Gout Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 🗹 Other (Specify) Hospice Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? (Month, Day, Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Koucetchen, D 6374 July 14, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 MUNCASTER MILL ROAD, ROCKVILLE, MD. JOCELYNE KOUATCHOU, M.D. 32. Régistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 🥎 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 1620 Ju1y 10 Elizabeth Parker 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept 2 Birthplace (State or Foreign Country) Year) Months Days Hours 1 ☐ M 2 ☑ F 77 217-28-8169 1931 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Maryland Anne Arundel Davidsonville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3892 Queen Ann Bridge Rd. 21035 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2X Married 1 □Yes 2√∑No Specify. Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Dietary Department College (1-4or 5+) Elementary/Secondary (0-12) 8th 0 State of Maryland Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William E. Byrd Annie Branford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 0 3 5 Thomas H. Parker Jr(Husband) 3892 Queen Ann Bridge Rd. Davidsonville, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 7-17-09 Lothian, Md. Adams UM Church 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee WinName Reddee of Rillisons Mortuary, 821 West St. Annapolis, Md. B. Beese MOUY83 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):

**Physician** /Medical Examiner

permit. Page Department of Important: If any Injury or once.

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

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**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, It. Medical Economy mans to be notified at any or other traumatic event, It. Medical Economy.

Baltimore, Maryland 21215-0036

burial-trai signed by the attending physician be detached for use as the buria should be has within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Sif Cth re Examiner Physician/Medical Pa ð Completed Be 25 Certification: To 27

Sequentially list conditions, if any, leading to immediate cause. Fine I berry Cause (Disease or injury that initiated events resulting in death) Last						
IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1	h 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23	id. Date of delivery Month Day Year		
Part II. Other significant conditions	141	in the underlying cause given in Part I.	23e. Did tobacco use  1 Yes 2 2  24a. Was an autopsy performed 2 1 Yes 2 2 No	e contribute to the cause of death?  3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No		
25. Was case referred to medical		26. Place of	Death (Check only one)			
examiner? 1 Yes 2 No	Hospital: 1 Impatient 2 ER/O	ng Home 5 Residence 6	Other (Specify)			
27. Mann of Death  1	(Month, Day, Year)	Time of lnjury at Work?  M 28c. Injury at Work?  1 □ Yes 2 □ No	28d. Describe how injury			
3 Suicide 6 Could not be determined		arm, street, factory, office	28f. Location (Street and City or Town, State)	f. Location (Street and Number or Rural Route Number, City or Town, State)		
		e, death occurred at the time, date and pnd/or investigation, in my opinion, death				
OOL Cignature of acrtifica		20a License number	20d Data	signed (Month Day Year)		

P00058797

within 24 hours a To the Funeral L

State Registrar

Medical

MD 10wte0 our 31. Date filed (Month, Day,

**JUL 15** 

Anne Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Could Amaphis MD Zito,

Physic /Medi Exami

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician** /Medical

Baltimore, Maryland 21215-0036

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pere 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

Registrar

	1 - State Registrar Certificate of Death Reg. No.									
40	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month North N									
ian	Roselle C. Prentice				July	Da:	6, 2009	1925 ™		
cal	4a. Facility Name (If not institution, give street and number	4b. City, Town, or	r Location of De			. County of Death				
ner	*		Location of B				_			
/G.	Laurel Regional Hospital	- (1 to a 4 to 4 to 4 - 1	Laurel  If Under 1 Year	If Under 24 I	Hrs. 8. Date of		rince Ge			
	5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthday)	Months Days			71921	9. Birth	place (State or Foreign Intry) AL		
	578-34-6103	87 Yrs.			00/1	7/1921		AL		
	Usual Residence of Decedent							404 1-14-03-15-3-		
	10a. State 10b. County 10c. City, Town or Location							10d. Inside City Limits		
Ş	MD Prince George's Laurel							1 XYes 2 No		
<u>s</u>	10e. Street and Number		10f. Zip Code				0g. Citizen of What Country?			
	13801 Belle Chasse Blvd.,	20707				TICA				
era	11. Marital Status 12. Was Deceden			lispanic Origin		USA 14. Race - Ameri	ican Indian,			
5	Armed Forces		Was Decedent of H f Yes, specify Cuba	Black, White	, etc.					
Completed by Funeral Director	1 □ Never Married 2 □ Married 1 □ Yes 2 □ If Yes, Give 3 □ Widowed 4 ☑ Divorced Year or Dates		1 □ Yes 2 <b>X</b> No	Specify: B1	ack					
d b						105 1	Cind of Dunings (I	n du ntm		
ete	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occup kind of work done DO NOT use retired	ation during most of	working	16D. N	(ind of Business/li	ndustry		
ם	Elementary/Secondary (0-12) College (1-4or	75+)		a)						
[등	9	Custo	dial				Federal Government			
Be (	17. Father's Name (First, Middle, Last)			18. Mother's	Name (First, Mid	ddle, Maider	n Surname)			
2	Albert Calhoun			Dora	Cliff					
-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street			ımber, City	or Town, State, Z	ip Code)		
	E1 . P. 1.	10001	D 11 01					m 0000		
-	Evelyn Prentice/Daughter  20a. Method of Disposition	20h Place of Dispo	Belle Cl	nasse B	Date #	4 1 () 1	LaureL, I ocation - City or 1	MD 20/0/		
	1 X Burial 2 ☐ Cremation 3 ☐ Removal from Stat	20b. Place of Dispo cemetery, crei	natory or other pla	ce)	Date	200. L	ocation - only or i	own, oute		
	4 ☐ Donation 5 ☐ Other (Specify)	Lincoln :	Memorial	0	7/23/200	09 Sui	itland, N	1D		
	21. Signature of Funeral Service Licer(see/	1 /7 22	2. Name and Addre	ess of Facility	Strickl:	and Fu	meral Se	ervices		
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD 20748									
	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate									
	shock, or heart failure. List only one cause on each line.									
	Immediate Cause (Final disease or condition condition a Cardiorespiratory arrest									
	resulting in death)  Due to (or as a consequence of):  Coronary artery disease									
١.										
ner										
Ē	Cause (Disease or injury that initiated events									
Ä	resulting in death) Last  Due to (or as a consequence of):									
/Medical Examiner	d									
ğ	W.									
Ž	IF FEMALE: 23c. If yes, outcome	ne of pregnancy					23d. Date of deli	very		
ä	23b. Was decedent pregnant 1 Live birth	2 Fetal death 3	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)				Month Day Year			
Physicial	1 Yes 2 No 9 Unknown									
5		una contributo ta	the eques of death?							
by	Part II. Other significant conditions contributing to death	111	23e. Did tobacco use contribute to the cause of death?							
		2∐No 3∏Pr	obably 4 X Unknown							
Completed		24b. Were au	topsy findings available							
물		prior to death?	completion of cause of							
							o 1 ∐Yes	2 □ No		
Be	25. Was case referred to medical examiner?		O#1	hor	f Death (Check o					
12	1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpa		II 3 DOA				6 ☐Other (Spec	cify)		
	27. Manner of Death  1 ☑ Natural 5 ☐ Pending (Month, I	njury 28b. Time o Day Year) Injury	of 28c. Inju Wo	ry at rk?	28d. Desc	Describe how injury occurred				
ä	2 ☐ Accident investigation	M 1 🗆	)							
<b>1</b> €	3 Suicide 6 Could not be determined 28e. Place of building	injury - At home, farm, st	reet, factory, office		28f. Locat	on (Street a	and Number or Ru	ıral Route Number,		
ert	4 ☐ Homicide determined building, etc. (Specify) City or Town, State)									
Medical Certification:	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
Jice	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
Mec	29b. Signature and title of certifier		29c. License number			29d. Date signed (Month, Day, Year)				
	12		P153.3			7/16/05				
	to to mo			12,2		11.21-3				
	30. Name and address of person who completed cause o	f death (Item 23a) (Type,	Print)							
0	Barry Paul Shapiro, MD, Laurel Regional Hospital, 7300 Van Dusen Rd., Laurel, MD 20707									
ate	31. Date filed (Month, Day, Year) 32. Regi	strar's Signature								
trar	JUL 2 0 2009 Devision >	7. parts								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death . 2009 **Physician** Margaret Anne Porter July 14, 8:10 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth (Month, Day, You Jan. 29, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 1946 1 □ M 2 1 F Days Hours Min 217-46-7976 Yrs Washington, DC Director 63 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, In Medical Eventine Inset Le matter and Injury or other traumatic event, In Medical Eventine Inset Le matter 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10506 Amherst Avenue 20902 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes ZE No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Cosmetologist Beauty 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leonard G. Porter Lucile Profe 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony Saridakis/Executor 1688 East Gude Drive, #102, Rockville, MD 20850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 🏞 Cremation 3 ☐ Removal from State July 16 Metropolitan Crematory 4 Donation 5 Dother (Specify) 2009 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22 Name and Address of Eacility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 and 23a. Part 1. Enter the disease, or complications that caused the ceuth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardiopulmonary Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Respiratory Failure Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consecuence of I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Terminal Chronic Obstructive Pulmonary Disease Exacerbation burial-trai resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year Month 5 ☐ Other (specify) 1 □Yes 2 X No 9 Hlnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 X Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 No 1 □ Yes 2 X No 1 🗀 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 🛣 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 🔀 Natural 1 ☐ Yes 2 No 2 Accident the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated

State Registrar 29b. Signature

Sirak Lemma, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

3

Box 68760.

P.O.

of Vital

29c. License number

1500 Forest Glen Road, Silver Spring, MD 20910

D65069

29d. Date signed (Month, Day, Year)

July 15, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene 23aPtII,25 per me. 8894,08/13/09dnb Red. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July July Day **Physician** inkett 135 AM a ttie 13 2009 Mae /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balti Move

9. Birthplace (State or Foreign Country) 07-Mainfalls Circle tows ville If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 8 Months Days Hours Min. 1 M 2 F 9 218-20-7072 oct. 10, 1910 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No **Funeral Director** BaltiMove +ONS VILLE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 22 USA Vainfalls 21 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural," or iten any Injury or other traumatic event, the Medical Eventione. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No 3altimore, Maryland 21215-0036 Specify: þ Specify: 3 Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Ь Work Someone else's home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ John Manokey Hattie Hughes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Circle Catonsville May y MD. 21228 Kose 7 Main Falls 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State reld Cemetery 7/18/09 Church Creek, MD. 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of acility HENRY 510 W FUNERAL HOME, 23a. Part Enter the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD. 21613 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardiopulmonory 5 min disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Recurren 4 month, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner MEDICAL EXAM! The law requires that the death certificate be executed ysphag ia den y Cars attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Syears Physician/Medical Cerebro Vascular IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) signed by the a 1 ☐ Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by intelerance Malnutrition 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Decub 1 tus 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No ers 24a Was an page 2 autopsy causes in Part Due Quadriplegic diffus pasticity 2 **X** No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA ို 5 Residence 6 □Other (Specify) this 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Natural

Accident 5 Pending investigation 1 ☐ Yes 2 □ No after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29b. Signature and title of 29c. License number

To the Hospital or Attending Physician; within 24 hours a completely

> State Registrar

30. Name and addre John

31. Date filed (Month

MD

2033

istrar's Signature

ss of person who completed cause of death (Item 23a) (Type, Print)

Serlemitsos

D39654

Pender brooke Drive, Crownsville

29d. Date signed (Month, Day, Year)

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) William Physician 2009 16 0405 H660++ KAVENSCrof /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ALLEGANY CUMBERLAND MEMORIAL HOSPITAL WMHS Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days MARYLAND 1**X**M 2□ F 186-01-5935 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No Funeral Director Lonazoning MARY AND 10g. Citizen of What Country? 10e. Street and Number 6 USA 21539 21 Furnace items 23a permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23: any injury or other traumatic event, if a We fiest Examiner must any injury or other traumatic event, if a We fiest Examiner must once. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Mo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 No Baltimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) COAL Elementary/Sacondary (0-12) COAL MINER 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DORIS Ellen KAVENSCrof ပ HArvey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ST. BArton DORIS Gillis -23705 Middle 20c. Location - City or Town, State 20a. Method of Disposition 22. Name and Address of Facility Eichhorn - Mcken zie 1. Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee Miken 8. 8 Enst MAINST. Longoning, 23a. Part Enter the disease, or compileations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Acute Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last or as a consequence of P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No 1 ☐ Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

6

900 Seton Drive,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. TArig 6 pula 31. Date filed (Month, Day, lear)

MIL 20

m.D

32. Registrar's Signature

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Cumberland,

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 57 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) : 45 AM July 20 2009 Norman Thomas Ream 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Garrett Co. Mem. Hospital 0akland Garrett 8. Date of Birth May 21, 9. Birthplace (State or Foreign Country) MD • If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min. 1 MM 2□ F 220-32-3806 73 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No Garrett 0akland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21550 1304 Broadford Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eunice Smith Bert Ream 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Brenda Glotfelty (daughter) 2639 Fingerboard Rd. Oakland, MD. 21550

**Physician** /Medical

**Physician** 

/Medical

Examiner

10a. State

MD.

**Funeral** 

Director

show

ral", or items 23a or 28a-f shov Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 2, any injury or other traumatic event, the Medical Examinar must be no once.

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

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the Maryland

Examiner

physician and s the burial-trans attending p signed by the a s certificate has b lirector, page 2 s 24 hours after death.

Funeral Director: After this certificetely filled in by the funeral director,

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

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	20a. Method of Disposition  1  Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State Tav 1	ce of Disposition (Name netery, crematory or oth Lor—Sines C	e of er place) Semetery 7/2:		Location - City or akland,	•
	21. Signature of Funeral Service Licens	udock		Address of Facility A Burdock th Second S	Funeral Ho t. Oakland	ne MD. 21.	550
	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)		Bowe	of tying, such es cerdiac	or respiratory errest,		Approximate Interval Between Onset and Death
Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Use to for as a consequence.  Due to (or as a consequen					
ysicialiymeulcal	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	eath 3 Ectopic pre		11:	23d. Date of de Month	olivery Day Year
volubleted by Fit	Part II. Other significant conditions or	intributing to death but not resulting	ng in the underlying cau	use given in Part I.		2 No 3 P	or the cause of death?  robably 4 🗹 Unknown  utopsy findings available completion of cause of  s 2 🗆 No
اي	25. Was case referred to medical			26. Place of Deat	th (Check only one)		
5	examiner? 1 ☐ Yes 2 💆 No	Hospital: 1 ☐ Inpatient 2 🗷 ER	3/Outpatient 3 □ DOA	Other: 4 I Nursing He	ome 5 🗆 Residence	6 ☐ Other (Spe	ecify)
TIOII.	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	8b. Time of 28d Injury M	c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in		
פוניוני	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, o	office	28f. Location (Street City or Town, St	and Number or R ate)	tural Route Number,
anical	29a. Certifier (Check only one)  (Check only one)	ysicien: To the best of my knowle ilner: On the basis of examination and manner stated.	edge, death occurred a n and/or investigation, i	t the time, date and place in my opinion, death occu	e, and due to the cause rred at the time, date a	e(s) and manner a and place, and du	as stated. e to the cause(s)
IAI	29b. Signature and fittle of certifier		29c.	License number	29d. 1	Date signed (Moni	th, Day, Year)
5	30. Name and pedress of person who c	-la A. Wold	MD. 3	11 North Forth	n stree	Oaklar	M2550
:	31. Date filed (Month, Day, Year)  JUL 2 2 200	32 Registrar's Signature	partel				1
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death <sup>Day</sup> 2009 July 19, **Physician** young 12:15 PM Joanne Stewart /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5425 Sheriff Road Capitol Heights Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) B. Date of Birth (Month, Day, Year) 03/24/1948 Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 □ M 3€3¢F 579-64-5177 61 Washington, DC Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City. Town or Location 10a. State 10h County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1X Yes 2 No MD Director PG Capitol Heights 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 may injury or other traumatic event, the Wolfiel Examinar matter and once. 5425 Sheriff Road 20748 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify If Yes, Give Year or Dates: Specify: Black Completed by 3 ₩ Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Engineerer Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur Young Barbara Lee ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Tracey Stewart - Daughter 13309 Buchanan Drive; Fort Washington, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 07/24/2009 Suitland, Maryland Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) of Funeral S-rvice 22. Name and Address of Facility Freeman Funeral Services 21. Sign nur 4594 Beech Road; Temple Hills, MD Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by leart failure. List only one hause on each line. Approximate Interval Between Onset and Death shock, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 Nes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an is certificate has director, page 2 s autopsy performed? 1 ☐Yes 2 ☐No 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) After th funeral 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 X Natural 5 Pending 1 □Yes 2 □ No investigation 2 Accident within 24 hours arer dearl To the Funeral Director completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suittland Maryland 207-46 . Verser Silver 5001 31. Date filed (Month, Day, State 2 0 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 2009 **Physician** 1225 M Edward J. Sabotka 12 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Micomica Kegional Medical Center Calisburg If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, July 18, Social Security Number Age (In yrs. last birthday) **Funeral** Days New York Min. 1 X M 2 □ F 86 July 094-16-9578 1922 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Expression rust be realised at 1 XYes 2 ☐ No Director Wicomico Salisbury Marvland filed within 72 hours after death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21804 USA 311 Hammond Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1942 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2K Married 1945 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "na any injury or other traumatic event once." (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Tobacco Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Unknown) (Unknown) ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Wife's Cynthia B. Malament/Guardian 11065 Cathell Road, Berlin, Maryland 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 7/18/2009 Delmar, Delaware Crematory of Delmarva 22. Name and Address of Facility Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean City Road, Salisbury, 21. Sig sture of Tuneral Service MD 21802 enu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ptis /Medical Due (or as a consequence of): Examiner 5 Chemic bowel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Merenteric Schemia burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Kenal 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen Preumoni 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 1 ☐ Yes 2. No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Hospital or Attending PhysIclan: The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records.

Baltimore, Maryland 21215-0036

completely within 2

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

Wilson Nino

MD

29c. License number

29d. Date signed (Month, Day, Year)

D63499

07/12/09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

12137 Elm Street

Princess Anne MD

31. Date filed (Month, Day, Year) JUL 20 2009

			For State Registrar	State of	Marylan	•	artment rtificate			nd M	ental Hygi	ene g. No. 2	nna	21.573
	Physici		Decedent's Name (First, Middle,	Janette E	thne S	oftleid					2. Date of Death Month <b>July</b>		Year <b>2009</b>	3. Time of Death  10:00 a M
3 A	/Medic Examir		4a. Facility Name (If not institution,			orciergi	Υ	wn or I	ocation of I	Death	July		nty of Death	
	Examir	ier	601 East Randol				4b. Oity, ic	,,, OI E	20904	Dodin		40. 0001	111/2=	gomery
	Funeral					last birthday)	If Under 1	Year	If Under 24	Hrs.	8. Date of Birth			place (State or Foreign
и	Director		335-44-5624	1 □ M 2 🕱 F	68	Vec	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, June 27,		Cour	sh Guiana
			Usual Residence of Decedent	1	0						Julie 21,	1741	DITLI	isii Gutalia
	land ow		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						1	0d. Inside City Limits
	Man,	ţ	Maryland Mon	tgomery				Si.	lver Sp	rino				1 ☐ Yes 2 🖬 No
	the 28a	Director	10e. Street and Number	egomer y			10f. Zip C		rver op	, Ing		a. Citizen c	of What Cour	ntrv?
	with with			oh Dood #20	7				20001			<b>3</b>		•
	eath	Funeral	601 East Randol	12. Was Decede		S 12	Was Dagada		20904	n2 (Sno	oifu Voc or No	14 B	U.S.	
	iten iten	Ë	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	Armed Force	s?	.3.	If Yes, specify	/ Cuban	, Mexican, F	Puerto F	cify Yes or No- Rican, etc.)		lack, White,	
36	rs af	b	3 Never Married 2 Name	If Yes, Give Year or Date	7		1 □Yes 2	No.	Specify:			Spec	cify:	D1 a al-
21215-0036	hou tura	- P	15. Decedent's			16a Dece	dent's Usual	Occupat	tion		1	6h Kind of	Business/Inc	Black
5	n 72	Completed	(Specify only highest	grade completed)		(Give	kind of work DO NOT use	done du		f workin		OD. MING OF	Dusiness/III	uustiy
7	withi ene. <b>thar</b>	Ĕ	Elementary/Secondary (0-12)	College (1-4c	or 5+)		inistra	U	Acciet	ant			Insuran	aco.
0 0	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Eventreer must be redified at		17. Father's Name (First, Middle, La	l		2101	IIIII				(First, Middle, M			
an	ontal ed o	Be		e Henery							Mavis Bou			
$\geq$	should be f and Mental   s marked ol	၉	19a. Informant's Name/Relationship			10h Mailir	na Address //	Ptront n	and Alexandra as				un Chaha Zin	On do )
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene titler 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be refitted at				C						Route Number,	-		Code
Ġ.	1 an Heal em 2		Hugh Colin Andre Che 20a. Method of Disposition	ormonderey -							eville, No		n - City or To	wn State
ğ	or of or of		1 ☐ Burial 2 🖾 Cremation 3	Removal from Sta	te Zob. i	Place of Dispo cemetery, crer	natory or othe	er place,	i			oc. Location	ii - City of 10	WII, State
₽	rtant Piury		4 □ Donation 5 □ Other (Spe		For	t Lincol				7/20	/2009	Brentwo	od, Mar	yland
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau		21. Signature of Funeral Service Lie	censee -		F		naldi	i Funer		ome, Inc.	er Spri	no Mar	yland 20904
Records, P.O. Box 68760,	certificate has been signed by the attending physician and more 2 should be detached for use as the burial-transit	Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown  Part II. Other significant condition:  Diabetes Mellitu  Hypertension	Due to (or a Due t	as a consequas a consequas a consequal as a consequence as a consequal as a consequence as a c	uence of):  uence of):  ancy I death 3 [ death 5 [	⊒Ectopic pre	ify)	n in Part I.		1 ☐ Yes	acco use co	3 ☐ Prob b. Were auto prior to co death?	eny Day Year  the cause of death? bably 4 Unknown basy findings available mpletion of cause of
		Be C	Systemic Lupus I 25. Was case referred to medical	Erythematosus	5				26 Place of	f Death	(Check only one		I L Yes	2 LIN0
	Attending Prhysician; or death. ector: After this certific by the funeral director,	To B	examiner? 1  Yes 2  No	Hospital:	atient 2 □	ER/Outpatier	nt 3 🗆 DOA	Other			ne 5 🗷 Resider		Other (Snacif	fv)
Ö 7	erth eral	L:	27. Manner of Death	28a. Date of I	njury	28b. Time of		. Injury	at		8d. Describe how			<i>y</i> /
0	tending releath.  tor: After the funera	et e	1 X Natural 5 ☐ Pending 2 ☐ Accident investigat		Day, Year)	Injury	M	Work? 1 ☐ Ye	s 2 No	,				
Division of	after des Directo	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		Injury - At ho etc. <i>(Specif</i>	ome, farm, stro	eet, factory, o	ffice		2	8f. Location (Str. City or Town,	eet and Nur State)	mber or Rura	al Route Number,
	vithin 24 hours after de To the Funeral Directe completely filled in by the	Medical C		Physician: To the be caminer: On the basis and manner	s of examina									
i i	Within Comp.	M	29b. Signature and title of certifier		1		29c. L	icense i	number		29	d. Date sigi	ned (Month,	Day, Year)
	12		Luft	of of	_2	)		DS	0913			Julv	16, 20	09
	10		30. Name and address of person wh	no completed cause o	f death (Item	n 23a) (Type	Print)		فيورو			July		
			Leighton Forres			, , , , ,		Suite	204.	Gree	nbelt. Mai	ryland	20770	
	Sta	te	31. Date filed (Month Day Year)	32. Regis	strar's Signa	Acres A	4	9	,			- 1155		
	Registr		JUL 17	2009	ww	p. 9	arked							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Helen Lillian SPECTOR 2009 8:45 A July 16, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring 618 Hyde Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 **V** F 90 103-12-2188 Director 27, 1919 New York Jan. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shov any Injury or other traumatic event, the "Modical Examination at Lean Milled at 1 ☐ Yes 2 No Directo Silver Spring Maryland | Montgomery 10g. Citizen of What Country? 10e. Street and Number United States 20902 618 Hyde Road Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 2 If Yes, Give Year or Dates 1 □Yes 2√□No Specify. Specify: white 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rose Schindler Henry Greene ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 618 Hyde Road, Silver Spring, MD 20902 Judy Marwick, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 07/17/09 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Capitol Hebrew Cemetery | Capitol Heights, MD 22. Name and Address of Facility Torchinsky Hebrew Funeral Home of Fune al S Torchinsky Hebréw Funeral Home 254 Carroll St., NW, Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death MONTHS Carcinoma Kidney **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-transi Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 C Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Coronary Artery Disease 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 2 No 1 ☐ Yes or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 National Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Natural neral Director: A 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d

To the Funeral Direct

completely filled in by determined 4 Homicide Hospital 29a, Certifier 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 16, 2009 D0041072

State Registrar

DHMH 17 Rev 1/2001

Kensington, Md.

32. Registrar's Signature

eneced

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10810 Connecticut Ave.,

31. Date filed (Month, Day, Year)

Azhar Manipady, M.D.

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last Day Year Month **Physician** MA 200 /Medical 4c. County of Death 4b. Çity, Town, or Location of Deatl give street and number) 4a. Facility Name (If not institut Examiner Momon Don If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 🛛 F Yrs. 89 Nov. 6, 1919 Maryland Director 218-38-2446 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 10a. State 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director MD Garrett Oakland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō USA 21550 8570 Oakland-Sang Run Rd. 238 Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? or Items 11. Marital Status Black White etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ White 3 Widowed 4 □ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hospital Housekeeping 12 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othn any injury or other traumatic event 17. Father's Name (First, Middle, Last) A. Blaine Wilburn Bertha Cross 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14800 Connecticut Ave., Cresaptown, MD Sandra A. Baier/Daughter Baltimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Grove Cemetery July 24, 2009 McHenry, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licensee P.O. Box 275, Grantsville, MD 21536 funde Part1. Ententhe disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Year Dav in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Records. 1 Yes 2 No 3 Probably 4 Unknown been sign Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has 1 Yes 2 No Division of Vital Hospital or Attending Physician: Be 25. Was care referred to medical examiner? 26. Place of Death Check onl one Other: 4 \( \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) Hospital: 1 Impatient <sup>2</sup> 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Mann of Death 28b. Time of Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. Ligense number 191 →July 22 2009 wno completed cause of death Item 23a) (Type, Print) 30. Name and address 9 り 1 Wel 311 N. 4th St., Oakland, MD 21550 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 24

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	For State Registrar					artment of I rtificate of				Reg. No.	C U U	9 245
n	1. Decedent's Name (i	First, Middle, L							2. Date of Dea Month	ath Day	Yea	3. Time of Dea
	Emma	P	Ε.		Thomas				July 1		009	3:10 p
	4a. Facility Name (If no			nber)		4b. City, Town, o	r Location	of Death			County of De	
	8912 Walk 5. Social Security Num			7. Age (In yrs	last birthday	Lanham	If Under	24 Hrs.	8. Date of Birt	h	9. B	eorge's sirthplace (State or Fo
	577-60-19		1 □ M 2 🔼 F	97	Yrs.	Months Days	Hours	Min.	(Month, Da Oct 28	y, Year)		Country) th Caroli
	Usual Residence of De	ecedent										
		0b. County		10c. C	ity, Town or L	ocation						10d. Inside City L
חובבום			George's	La	nham							1 <b>½</b> Yes 2[
5	10e. Street and Number					10f. Zip Code				10g. Citiz	en of What (	Country?
3	8912 Walke	erton D				20706					SA	
Lane	11. Marital Status	. O Marria	12. Was Deced	ces?	J.S.   13.	Was Decedent of If Yes, specify Cub	Hispanic Or an, Mexica	rigin? (Spe in, Puerto l	ecity Yes or No- Rican, etc.)	- 1	4. Race - Ar Black, Wh	merican Indian, nite, etc.
2	1 ☐ Never Married 3 🖼 Widowed 4 [	_	1 ∐Yes If Yes, Giv Year or Da	e		1 ☐ Yes 2 🖾 No	Specify:	:			Specify: B	31ack
		5. Decedent's			16a. Dec	edent's Usual Occu	pation		1	16b. Kir	d of Busines	ss/Industry
2	(Specify	only highest g	rade completed) College (1-	Aor 5+)	(Give	e kind of work done DO NOT use retire	during mos	st of workii	ng			
Completed	Elementary/Second	1	College (1-	401 5+)	Prop	erty Mana	ger			Gov	ernmen	nt
De	17. Father's Name (Fin	rst, Middle, La:	st)				18. Moth	er's Name	(First, Middle,	Maiden S	Surname)	
2	John Ellid	ott					Beu1	ah E	vans			
	19a. Informant's Nam	e/Relationship	(Type. Print)		19b. Mail	ing Address (Stree	t and Numb	er or Rura	al Route Numb	er, City or	Town, State	e, Zip Code)
	Bettye T.	Brisco	e/daught	er	8912	Walkerto	n Dri	ve,	Lanham,	MD	20706	
	20a. Method of Dispos		☐ Removal from S	20b.	Place of Disp cemetery, cre	osition (Name of ematory or other pla	ice)		ate	20c. Loc	cation - City	or Town, State
	4 Donation 5-				ncoln	Cemetery		Jul 1	7 2009	Sui	tland	, MD
	21. Signature of Fune	al Service Lic	ensee		2	22. Name and Addr						al Home
		CO	1		7	474 Land	over I	Road,	Landov	ær,	MD_20	785
	23a. Part 1. Ent 1116 shock, or heart 1		mplications that ca ly one cause on ea		th. Do not er	nter the mode of dy	ing, such as	s cardiac o	or respiratory a	rrest,		Approximate Interval Between
Ì	Immediate Cause (Findisease or condition	nal	Arte	eriosc.	lerosi	s Cardiov	ascul	ar Di	isease			Onset and Dea
Ì	resulting in death)	- 1		or as a conse								
	Sequentially list condi	itions,	b	ertens								
Examiner	Sequentially list condi if any, leading to imme cause. Enter Underly Cause (Disease or inj	ediate ring	Due to (	or as a conse	quence of):							
Xan	that initiated events resulting in death) Las	_	C	or as a conse	quence of):							
				or as a sorise	quonoc 01).							
ğ			d									
/IME	IF FEMALE: 23b. Was decedent p		23c. If yes, out	come of pregr	nancy						3d. Date of	deliven
cial	in the past 12 mg	onths?		irth 2 Fel		☐ Ectopic pregnar ☐ Other (specify)	су				Month	Day Yea
Physician/Medical	9 ☐ Unknown	40	9 🗆 Unkno	own								
Dy P	Part II. Other significa	ant conditions	contributing to de	ath but not re	sulting in the	underlying cause g	ven in Part	l.	23e. Did t	obacco u	se contribute	e to the cause of dea
g	Alzheime	r's Di	sease						1 🗆 '	Yes 2	□ No 3 □	Probably 4⊠ Uni
Completed	Hypothyr	roidism	i						24a. Was	an	24b. Were	autopsy findings av
Ē										rmed?	death	
ל ב מ	25. Was case referred	d to medical	_				26 Plac	o of Doath	1 ☐ Yes	2½ No	1 □ Y	′es 2 □No
- 1	examiner? 1 ☐ Yes 2 ☑ No		Hospital:	npatient 2	∃ EB/Outpati	ent 3 DOA Of	hor:		me 5 🖾 Resi		C □Other /S	Precify)
-	27. Manner of Death		28a. Date	of Injury	28b. Time	of 28c. Inju	ıry at		28d. Describe			респу)
	1 X Natural 2 ☐ Accident	5 Pending investigat		h, Day, Year)	Injury		rḱ? ⊡Yes 2.⊑	]No				
<u> </u>		6 Could not determine	28e. Place	of Injury - At I	nome, farm, s	treet, factory, office						Rural Route Numbe
:	4 🗀 Homicide		Duliqui	ng, etc. <i>(Sp</i> ec	iny)				City or To	wn, State,	,	
٧						ath occurred at the						
	(Check only 2 one)	☐ Medical Ex	aminer: On the ba		nation and/or	investigation, in my	opinion, de	eath occur	red at the time,	date and	place, and o	due to the cause(s)
		Le of certifier	/			29c. Licer	se number			29d. Dat	e signed (Mo	onth, Day, Year)
edical	29b. Signature and tit		/	- 7	~							
edical	29b. Signature and tit	min	eli-	, re		D 4	L945			07/1	7/2000	9
Medical Certification: To	30. Name and address Cielito A					e, Print)				07/1	7/2009	9

			1 - State of Registrar	Maryland / Dep	ertificate of l			iene eg. No. 🤈 🗀	19 21.582
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month 07	Day Y	(ear 3. Time of Death
	/Medic	al	Esther Tanenbaum	t and	4h City Town or	Leastion of Death	07	4c. County of	009 4:00 A M
*	Examin	er	4a. Facility Name (If not institution, give street and num Bedford Court 3700 Inter			Location of Death		Montgo	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth	1 9	9. Birthplace (State or Foreign
	Director		050-03-8391 <sup>1□ M 2</sup> ▼F	100 Yrs.	Months Days	Hours Will.	11-30-1	908	New York
	and		Usual Residence of Decedent  10a, State 10b. County	10c. City, Town or L	_ocation		<u>.</u>		10d. Inside City Limits
di.	Maryl -f sho	ţ	MD Montgomery	Silver S	nring				1X∏Yes 2 □ No
	r 28a	Director	10e. Street and Number	011101	10f. Zip Code		10	0g. Citizen of Wh	at Country?
	th with		3700 International Drive	<u> </u>		20906		USA	
036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examinar rust be natified at	by Funeral	11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Decer Armed For 1 ☐ Yes If Yes, Giv Year or Da	2 MX No e	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	ispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black,	- American Indian, White, etc. White
9500-61212	thin 72 hor ne. nan "natur. Nedicel	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-	(Giv	pedent's Usual Occup we kind of work done of DO NOT use retired	during most of worki f)	ing	16b. Kind of Busi	·
	led wi Hygier her th		12		Book Keer	ner 18. Mother's Name			Industry
Maryland	the find the	o Be	17. Father's Name (First, Middle, Last) Harry Tanenbaum				a Kusvet		'
2	should nd Me mark matic	۲	19a. Informant's Name/Relationship (Type. Print)	19b. Mai	iling Address (Street				tate, Zip Code)
Baltimore, Ma	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner rust be notified at once.		Blanche Rosenfield / sis	20b. Place of Disp cemetery, cri	5 Interlact position (Name of ematory or other place al Cremeto	ce)	Date	20c. Location - C	Spring,MD20906 ity or Town, State nurch, VA
Ħ	permit. P Departme Importan any injury	9	4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Sance Licensee	1	22. Name and Addre	ss of Facility	1		al Direction,In
	Physician /Medical Examiner sthe partial-transit	Examiner	23a. Part1. Enter the disease, or complications that cashock, or heart failure. List only one cause on earn disease or condition resulting in death)  Sequentially list conditions, it can be cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events	used the death. Do not e		ville Pike	, Rockv	ille,MD	
O. Box 68760,	The law requires that the death certificate be ate has been signed by the attending physicis page 2 should be detached for use as the bur	Physician/Medical	in the past 12 months?	ant at time of death 5	B□ Ectopic pregnanc □ Other (specify)	у		23d. Date Mont	of delivery th Day Year
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al Reco	ician: The law requii certificate has been s ector, page 2 should	Completed	Hypertension				24a. Was a autops perforr	med? de 2 <b>X</b> INo 1[	ere autopsy findings available ior to completion of cause of eath? Yes 2 □ No
5	ysician: nis certific director, I	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Ii	npatient 2 ☐ ER/Outpati	ient 3 DOA Oth	er: 4 X Nursing Ho		ence 6 ☐Other	(Specify)
Division of Vital Records,	ding Pt .r After th funeral	Certification: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending investigation investigation		of 28c. Injur Wor M 1 🗆	Yes 2 □No		ow injury occurred treet and Number n, State)	d r or Rural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Co	29a. Certifier (Check only one)  1. Certifying Physician: To the base and mann and m	sis of examination and/or	eath occurred at the ti investigation, in my o	me, date and place, opinion, death occur	and due to the cred at the time, d	cause(s) and mar late and place, ar	nner as stated. nd due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier		29c. Licens	se number	2	29d. Date signed	(Month, Day, Year)
	1		1 & form		D18	726		July 11	, 2009
			30. Name and address person who completed cause		e, Print)				
			Arthur Schoengold 1811	l Prince Phi	lip Dr. T	-10, Olne	y, MD 20	832	
	Sta Registr		31. Date filed (Month Day, Year) 7 2009 32. P.	gistrar's Signature	parke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 5:35 F M Phyllis Lee Vallario /Medical County of Death 4a, Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death **Examiner** Dicomico 60 If Under 1 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday. Security Number **Funeral** Months Days 2/18/1942 Washington DC 1 □ M 2 🛣 F 213-40-9635 67 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, its Modical Examiner must be notified at 1 XYes 2 No **Funeral Director** MD Worcester Ocean City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Baltimore, Maryland 21215-0036 147 Old Wharf Rd. 21842 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 □XNo If Yes, Give Year or Dates: Specify. Specify white 3 Widowed 4 XDivorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Project Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vernon Unger Margaret Krause 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry Vallario / son 698 Pleasant Dr., Ocoee, FL 34761 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/17/2009 | Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funda Service Licensee 108 William St., Berlin, MD 21811 23a. Part 1. Enjerthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition CARCINDINA **Physician** MALIGNANT LUNG resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Que to for as a consequence of Due to (or as a consequence of): as the burial-P.O. Box 68760. the attending physician certificate be Physician/Medical IF FFMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ❤️nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ⊑ or Attending Physician; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 2/€ No 1∐Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: completely filled in by the fi 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 00058410

BA 10

State Registrar 31. Date filed (Month, Day, Year)

JUL 17 2009

32. Reg

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

S. park

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24584 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 09 18:46M Hemore /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Wicomico peninsula Regional medical center 8. Date of Bilth (Month, Day, Year) 4/20/1943 (In yrs. last birthday, 66 Yrs. If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 □**X**M 2 □ F Months Days Hours Min 213-40-7579 Director Washington DC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28a-f show D\_partment of Health and Mential Hygiene.
Important: If tem 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be multipled at other. 1 ☐ Yes 2 No **Funeral Director** MD Wicomico WIllards 10g. Citizen of What Country? 10e Street and Number 10f Zin Code 7660 01d Mill Rd. USA 21874 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after of and Mental Hygiene. Is marked other than "natural", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify. If Yes, Give Year or Dates þ Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public Relations Director Public Relations 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jim Weldon Whittemore Ruth Gertrude Whitlock 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 ment of Health Ellen Whittemore / wife 7660 Old Mill Rd., Willards, MD 21874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/17/2009 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. Frankford, DE 22. Name and Address of Facility 21. Signature of Fune at Service Licensee Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Ther II. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 4 Unknown 1 🗌 Yes 2 No 3 Probably Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an O 1 TYes 2 | No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation death. 2 ☐ Accident 1 ☐ Yes 2 🗆 No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of p BA3 100E. ST. SAlisbury Md WIELAND 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JUL 17 2009

				Please	Type or Prin	nt in B	Black In	delible ink	. Ensure A	II Copie:	s Are	Legi	ible.	
			. For		State of Ma	arylan	d / Depa	artment of I	Health and N	lental H	ygien	e _		01 -0
		1	State Registrar				Cei	rtificate of	Death		Reg. N	.Z U	109	24583
Die			1. Decedent's Name	ne (First, Middle, La	ast)	_				Date of D    Month		ay	Year	3. Time of Death
	ysicia Medic		Jam	es He	irman (	wild	esen	l .		7	18		2009	10:55 PM
	camine		4a. Facility Name (I	If not institution, gi	ve street and number)				or Location of Death		41	c. County	y of Death	
7			Donnett	Road	Menor			Dak	land			Ca	200	ett
Fur	neral		5. Social Security N	Number 6.			ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B	irth	r)	9. Birth	place (State or Foreign
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를 <u>1</u>	20		10e. Street and Nur	mber				10f. Zip Code			10g. C	itizen of	What Cou	ntry?
th w	ust b	<u>e</u> [	548 1	Wildesen	Rd.			2155	0			U.S	.A.	
5-0036 72 hours after death with the Maryland natural" or items 23a or 28a-f show	E	Funeral Director	1. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S	S. 13. \	Was Decedent of I	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or N Rican, etc.)	0-		ce - Ameri	can Indian,
after or it	E .		1 Never Marri	ied 2 Married	1 ☐Yes 2 🐼 1 If Yes, Give	No		1 □Yes 2 No		riloari, otor,				etc.
ours are	EX	5	3 🔀 Widowed	4 Divorced	Year or Dates:			100 200	орсону.			Specif	wh:	ite
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If the 27 is marked other than "natural" or items 28a or 28a-f show	dies.	Completed	(Spec	15. Decedent's E	ducation ade completed)		16a. Deced	dent's Usual Occup	pation <i>during most of work</i> d)	ina	16b.	Kind of B	Business/Ir	ndustry
7 if e f	9	ᇎ	Elementary/Seco		College (1-4or 5	+)			d)					
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ind be fil tal ⊢	even	ă	17. Father's Name	•	•				18. Mother's Name	•			ne)	
Vald Mer Mer arke	atic	<u> </u>	Frank	W1.	Ldesen				Berty	e Cha	ance			
Maryland of 2 should be file lith and Mental H;	anm		19a. Informant's Na				1	-	and Number or Rur					p Code)
and and ealth	her tr	-	Edward	S. Wilde	esen (son)		1		esen Rd.	Oakland	1, M	<b>D.</b> 2	1550	
of H	to l		20a. Method of Disp	•	Removal from State	20b. Pi	lace of Dispo	sition (Name of natory or other pla	ce)	Date	20c. l	_ocation	- City or T	own, State
Baltimore, permit. Pages 1 ar Department of Hea moortant: If item	À			5 ☐ Other (Speci				e Cemete		/09	0ak	land	, MD	21550
alti mit. partr	any inju		21. Signature of Fu	neral Service Lice	nsee	<u> </u>	22	Name and Addre	ess of Facility Burdock	F	1 110		D 4	
<b>©</b> 88 E	E 8		) ( Pa	and A	Burdos	k		21 N. Se	cond St.	oaklaı 0				)
			23a. Part . Enter ti	he disease, or con	plications that caused	the death	. Do not ente							Approximate
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/Med	_		disease or condition resulting in death)	on	a. 1 CW			Failu	re					mo with
Exam	_				Due to (or as	a consequ	ence of):						1	
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Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Immediate Cause (Final disease or condition resulting in death)	a. A Cuto R Due to (or as a conseque	ence of):	lure			Hum
Sequentially list conditions, frank, leading to immediate cause. Either Unionying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseque  c. Due to (or as a conseque  d.					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of de	death 3 🗆 Ectopic preg			23d. Date of de Month	ivery Day Year
Part II. Other significant conditions Reval	contributing to death but not result		se given in Part I.		1	the cause of death?
				24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
25. Was case referred to medical			26. Place of De	ath (Check only one)		
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient 3 DOA	Other: Nursing	Home 5 ☐ Residence	6 □Other (Spe	cify)
27. Manner of Death  1	28a. Date of Injury (Month, Day, Year)		Injury at Work? 1 □ Yes 2 □ No	28d. Describe how inj	ury occurred	
3 ☐ Suicide 6 ☐ Could not 9 determined		ne, farm, street, factory, of	fice	28f. Location (Street City or Town, Sta		ıral Route Number,

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 4.301 UNE NESSLING 13 1112 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Montgomery Burtonsville Sanctuary at Holy Cross If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 ☐ M 2 🖼 F June 13 1916 317-07-7071 93 Indiana Director Usual Residence of Decedent with the Maryland 10d Inside City Limits 10c. City. Town or Location 10a. State 10b. County your i r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 MNo Silver Spring Md. Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20905 15383 New Hampshire Avenue United States · death v Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural"; or Ite 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: White þ 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fisher Elizabeth Joseph Schaffstein 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2205 Winter Garden Way, Olney, Md. 20832 Jan J. Wessling / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 7/15/09 Alexandria, Va. 4 □ Donation 5 □ Other (Specify) Metropolitan Crem. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Muriel H. Barber Funeral Home Xo 20882 Box 5038, Laytonsville, 0. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final THEROSCLEROTIL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE: nse 23c. If ves, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 □Ectopic pregnancy for in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) ed by the a detached for 2 No 9 Unknown 9 Unknown been signed k should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown HYPERTENSION SAINE 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 performe death?
1 ☐ Yes certificate SACK 20 No 2 No within 24 hours after death.

To the Funeral Director; After this certifical completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 1 TYes 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 27. Manper of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Hospital or Attending Physician:

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

sulle

2835 32. Regir trar's Signature 31. Date filed (Month, D

UUN

1 crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

The Certifying Physician: To the best of the Mineral Research and the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HISN EEM

WE, SUITE 203, BACKO MA 21209

			1 _ State	of Maryla		artment of F				0 01.597
			Registrar  1. Decedent's Name (First, Middle, Last)		06/	incate of i		2. Date of Dea		3. Time of Death
	hysicia		Glorina	в. в	aquiran			Month July	29 , 2009	6:42 P M
	Medio/ Examin		4a. Facility Name (If not institution, give street and I		1		r Location of Deatl	n -	4c. County of	
			12702 Veirs Mill Road,	#103		Rockv				tgomery
	ıneral		5. Social Security Number 6. Sex  5.77. 70. 10.66 1□ № 2፟ F		rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da October 1	th ey, Year)	Birthplace (State or Foreign Country)
Di	rector		577-70-1966 Tunal Residence of Decedent	78	Yrs.			October I	10, 1930 P	hillipines
land	M II		10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
Mary	find 3	ţ	Maryland Montgomery		Rock	ville				1 □Yes 2 🔯 No
h the	r 28a	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	nat Country?
th wit	23a c	al	12702 Veirs Mill Road,	#103		2085	53		United S	States
r dea	ems	Funeral Director	11. Marital Status 12. Was De Armed	cedent Ever in Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	14. Race Black	- American Indian, White, etc.
s afte	or in	by F	If Yes.	Give		1 □Yes 2 No	Specify:			Filipino
hour	itural al Es		3 ☐ Widowed 4 ☐ Divorced Ye ar or  15. Decedent's Education	Dates:	16a. Dece	dent's Usual Occup	ation		16b. Kind of Bus	iness/Industry
in 72	n "na	Completed	(Specify only highest grade complete		(Give	kind of work done of DO NOT use retired	during most of word)	rking		,
d with giene	tha th	ĕ	Elementary/Secondary (0-12) College 4	(1-4or 5+)	Acco	untant			Union	n .
a Hile a Hy	d other	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle,	, Maiden Surname	)
2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.	arkec atic e	ည	Tomas Baquiran, Sr.				Enriqu	ieta Bas	a	
2 sh	'is m raum		19a. Informant's Name/Relationship (Type. Print)	<del>.</del>		ng Address (Street				state, Zip Code) • Maryland 20874
1 and Health	em 27		Emelita B. Baquiran / S  20a. Method of Disposition							ity or Town, State
Pages nent of	t: # ite		1 Burial 2 Cremation 3 Removal from	n State 1		sition (Name of matory or other plac ven Cemeter		st 3,		
nit. P	Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercitive rount be rediffied at once.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	Ga			-			ring, Maryland
permit. Departn	any ir		Myseletteranit	— <sub>мо1</sub>	.305 30	2. Name and Addre bert A. Pur O West Mont	mphrey Tune gomerv Ave	eral Home/ nue, Rock	Rockville, ville, Mary	Inc. Vland 20850-2805
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause or	caused the de			0 -	-		Approximate Interval Between
Phys	sician		Januaritata Carras (Final	alnutri	ton					Onset and Death
/Me	edical		resulting in death)	o (or as a cons						
Exa	miner		Sequentially list conditions		suffici	ency				
pa	sit	ine	cause. Enter Underlying Cause (Disease or injury	o (or as a cons	equence of:					
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ate be executed	ysician and e burial-transit		d	, =	,					
<b>7</b> 0	도도	Physician/Medical								
th cer	attending p for use as	N/ue	23b. Was decedent pregnant	outcome of preg		☐ Ectopic pregnanc	V			of delivery
The law requires that the death certific	he at	sick	1 ☐ Yes 2 🖾 No 4 ☐ Pro	egnant at time of		Other (specify)			Mon	th Day Year
nat th	ned by the a detached i	Ph	9 ☐ Unknown  Part II. Other significant conditions contributing to	death but not r	esculting in the u	nderlying course giv	on in Part I	23a Did t	tobacco use contril	oute to the cause of death?
ires t	signe	ģ	Cerebrovascular Acci		esalang in the a	ilderlying cause giv	en in rait i.			B □ Probably 4 🖾 Unknown
v requ	s been sign	Completed						24a. Was	an 24h W	ere autopsy findings available
he lay	10 10	due						auto <sub>l</sub> perfo	psy pr prmęd? de	ior to completion of cause of eath?
E :	tificat or, pa	ပိ	25. Was case referred to medical				26 Place of De-	1 ☐ Yes ath (Check only o		□Yes 2□No
ysici	this certificate ha	To B	examiner?	Inpatient 2	☐ ER/Outpatier	nt 3 DOA Oth			idence 6 Othe	r (Specify)
Attending Physician: r death.	fter th		27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Me	te of Injury onth, Day, Year)	28b. Time o	f 28c. Injur Worl		T	how injury occurre	
endir	or: A	satic	2 Accident investigation				Yes 2 □ No			
or Att	<b>Direct</b> in by	Certification:	datermined 28e. Pla	ce of Injury - At Iding, etc. <i>(Spe</i>	t home, farm, str ecify)	eet, factory, office		28f. Location ( City or To		r or Rural Route Number,
pital ours a	filled		29a. Certifier 1.2 Certifying Physician: To t	he hest of my l	mowledge deat	h occurred at the ti	me date and plac	e and due to the	cause(s) and mar	oner as stated
To the Hospital or Attending Ph within 24 hours after death.	e Fun letely	Medical	(Check only 2 Medical Examiner: On the							
<b>To th</b> within	To the	Me	29b. Signature and title of certifier			29c. Licens				(Month, Day, Year)
			J. Ke wet che	_		063	3748		July 30	, 2009
(0)			30. Name and address of person who completed ca							- 0005-
V	<b>V</b>		Jocelyne Kouatchou, M.D	Degiotrario Cia	matura		Road, Roo	ckville,	Marylan	d 20855
	Sta Registra		31. Date filed (Month, Day, Year) 32.	Registrar's Sig	gnature					
	31311		JUL 3 I ZUUS CERTI	TO 10.	17					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 23b,c per doc g894 8-18-09 yt

Amend Item 26 per verb., g893,07731709dhb

Certificate of Death

Reg. No. | | | | 1 - For A State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 29<sup>Day</sup> **Physician** 2009 7:15 Lena F. Ballard A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Kindley Assisted Living Building Montgomery Gaithersburg 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Months Days Hours Min. 1 11/14/149 28°) 1 □ M 💯 F 80 403-46-4963 KY Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Oppertment of Health and Mental Hyglene.
Important: If flem 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It's Madical Exprise must on must be notified. Director 1 ☐ Yes 2 No MD Howard Ellicott City 10e Street and Number 4112 Heritage Hill Lane 10g. Citizen of What Country? United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣ No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify. þ Specify: ¥ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7. and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Reading Specialist Balt CO Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George W. Finch Thelma Jones မ 19a. Informant's Name/Relationship (Type. Print)
Alicia Ballard (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $1728\,$  N. Rhodes St. #279 Arlington, VA 2220120a. Method of Disposition Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State P⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 8/5/200 Ezel, KY Ezel Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Burrier-Queen Funeral Home and Crematory, P.A. hellow 1212 W. Old Liberty Rd. Winfield, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ARREST disease or condition resulting in death) ARDIODUL /Medical Due to (or as a consequence of): Examiner Colon Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine to (or as a consequence of) • Hospital or Attending Physician: The law requires that the death certificate be executed 24 brouss after death.
• Funeral Director: After this certificate has been signed by the attending physician and etely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) P.0. 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ icate has been się r, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 □ Yes 2 100 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Assisted
6 Assisted
Cother (SpecifyLiving Other: 4 \sum Nursing Home 1 ☐ Yes 2) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA esidence Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely (Check only one) within 2 To the I 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 100 DR-32. Redistrar's Signature 31. Date filed (Month, Day, Year) State 2104 Dark Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 19b Per FH 8893 //31/09 TT
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 11:58 PM Hazel Louise Boulware 26 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St Agnes Hospital Balti more If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Hours Months Days Min. 1□ M & □ F Director 82 12 16 26 NC 242-32-1795 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 ☑ No Director MD Baltimore Catonsville 10e, Street and Number 10g. Citizen of What Country? "natural", or Items 23a Funeral 701 Edmondson Ave 21228 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2√□No Specify: þ Specify: Black 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Item Me Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 2yrs <u>Printer</u> <u>Advertising Company</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Wooten Chester Holman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lesan Lessaan Road. Randallstown, Md 21133 8908 Council Boulware-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Crematory Inc 7/30/2009 Baltimore, Md 22. Name and Address of Facility March F/H West 4 □ Ponation 5 □ Other (Specify) 21. Sig ature of Funeral Service Licensee 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Findisease or condition) 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death Preumo Koral **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): be executed j physician and is the burial-trans Due to (or as a consequence of): P.O. Box 68760 Physician/Medical The faw requires that the death certificate attending p for use as t IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day detached 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an rector, page 2 s autopsy perform 1 ☐Yes 2 ☐ No Division of Vital 1 ☐ Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Medical Certification: To After th funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. 5 Pending investigation 1 ☐ Yes 2 ☐ No ieral Director: / filled in by the fi 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Hamicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c, License number Medic 24385 Inter 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PE ZAR 31. Date filed (Month Day Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Boul

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-05794 State of Maryland / Department of Health and Mental Hygiene 2009 24590 Cynthia Brown Certificate of Death 1- For State Reg. No Registrar 2 Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day July 24, 2009 2253 hrs Brown **Medical Examiner** Jean Cynthia 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore 4209 Ridgewood Avenue Apt. 2E If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Hours Months Country) SC Director 04 54 08 250-96-0471 М  $^2X^F$ 55 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 1 X Yes 2 No Baltimore items 23a or 28a-f show ust be notified at once. NA death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21215 4209 Ridgewood Ave Apt 2E 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. Armed Forces? 1 X Never Married 2 X No Yes Black Specify 1 Yes 2 X No specify: Pages 1 and 2 should be filed within 72 hours after onen of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", on If Yes. Give Year 4 Divorced Widowed 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) or other traumatic event, the Medical Disabled Disabled MD 21215-0036 10th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Virginia Noles Be Thomas Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 5016 Denwood Ave, Baltimore, Md 21206 April Dixon-Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) Removal from State Burial 2 Cremation 3 Baltimore, 7/29/09 permit. Pages
Department or
Important: 1
injury or oth Trinity Donation 5 Other Specify: 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md ure of Funeral Service License 21215 Approximate Interval ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Part I. Enter the disease, or complications that caus failure. List only one cause on each line. **Physician** Between Onset and Death Medical Atherosclerotic cardiovascular disease Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated WS Due to (or as a consequence of): events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed X AMENDED 23a,2/,perME, g894 8/19/09 TT Item#5perFH,G894,8/4/09,WS and Physician/Medical X UNPENDED ending physician use as the burial Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Day 3 Ectopic pregnancy Month 23b. Was decedent pregnant in the Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 ✓ Unknown g Unknown certificate has been signed by the ector, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 No 3 Probably 4 Unknown ò Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? No 1 V Yes ✓ Yes 2 No 26.Place of Death (Check only one) After this certific funeral director, J 25. Was case referred to medica Division of Vital Be Other Nursing Home 5 Residence 6 Other: Scene Hospital: 1 ER/Outpatient 3 Inpatient 2 ۵ 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No Pendina 24 hours after death. Funeral Director: Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 25, 2009 O.C.M.E. Monte hell

osend State Registrar

32. Redistrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Margarita Korell MD. 31. Date filed (Month, Day, Year) Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 Per Phy G894 8/13/09 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Giuseppina Argentati **Boldrini** 3. Time of Death **Physician** Day 12:50 A M 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Baltinon, Mrs Manyland Med cote If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/27/1958 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□м 2₩ F Months Days Hours Min 196-76-4418 51 Ĭťaľy Director Usual Residence of Decedent death with the Maryland show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heatih and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-1 shot ary or other traumatic event, It is in Caro in a notified at Director PA 1 ☐ Yes 2 ☐ No Luzerne Pittston Township 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 81 Frothingham Street 18640 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No If Yes, Give Year or Dates: \$ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 Elementary/Secondary (0-12) College (1-4or 5+) Bookeeper Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leonello Argentati Rinalda Pastorelli 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Antonello Boldrini (Spouse) 81 Frothingham Street, Pittston Township, PA 18640 permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Sassoferratto, Italy Catobagli Cemetery 08/13/2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, 21. Signature of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Intrabadoninal disease or condition resulting in death) /Medical Due to (or as a consequence of): 7 days Examiner Recet operation 1/21) Colon cancea Sequentially list conditions, iner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami and burial-trar law requires that the death certificate be execu Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the 9 Unknown 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ with 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed Were autopsy findings available prior to completion of cause of death? has autopsy Hospital or Attending Physician: The performed' certificate 1 Yes 2 □ No 1 Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∐No 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA မ After thi funeral o 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending ithin 24 hours after death.

The Funeral Director: After the properties of the function of the 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kec T-P23096 7/28/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO Turner. 22 Bullinon. HD N. Gree 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State JUL 3 1 2009 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Neural alam	1	Registrar . Decedent's Name (First, Middle, Last)	ertificate of Death	2. Date of Deat	The state of the s	3. Time of Death
Physician /Medical Examiner		Hilda Barbara Biondo a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of De	July 28		
uneral irector	5	Riverview Nursing Home Social Security Number 217-26-7305    Sex   The management of the security Number   7. Age (In yrs. last birthout the security Number   102	Months   Davs   Hours   M	8. Date of Birth (Month, Day, Sept. 4,	9. Birth Year) Cou	place (State or Fore intry) rland
or 28a-f show be notified at Director	1	Sual Residence of Decedent	Parkville		Og. Citizen of What Cou	10d. Inside City Lim 1 ☐ Yes 2  Intry?
23a or 2 ust be no		0e. Street and Number 8327 Old Harford Road	10f. Zip Code 21234		USA	
al", or items 23a Examiner must	2	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin: If Yes, specify Cuban, Mexican, Pi  1 □ Yes 2 No Specify:	uerto Rican, etc.)	Black, White	, etc. nite
d other than "natura event, the Medical E	paladuo	(Specify only highest grade completed) ((	ecedent's Usual Occupation Sive kind of work done during most of fie. DO NOT use retired) etail	working	Hecht Compa	•
arked other	0 00	17. Father's Name ( <i>First, Middle, Last</i> )  Christian Wehner		Name (First, Middle, ret Ried		
27 Is mar r traumat		19a. Informant's Name/Relationship (Type. Print)  Charles Biondo-son  19b. N	Mailing Address (Street and Number of 27 Old Harford Ro	ad-Parkvil	le,Maryland	1 21234
Department of frequent and months in 1990.00.  The model of the model		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Disposition (Name of crematory or other place) Heart Of United Street Of United Street	1y 31, 2009	Dundalk,	Maryland
any in		21. Signature of Funeral Service Licensee  23a. Part1, Enter the disease, or complications that caused the death. Do no	Evans Funeral and Cremation	<u>Service</u>		ford Roa MD 21234 Approximate
/sician ledical aminer ituansit	EXA	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of Due to (or as a consequence	):	m Dise		
sician	ल्र					
attending physicia for use as the bur	ıysıcıan/Medical	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  d.  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (spec/fy)		23d. Date of de Month	
igned by the attending physicia be detached for use as the bur	by Physician/M	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☑ No ☐ Hoknown	5 Other (specify)		Month	Day Yea
has been signed by the attending physicia e 2 should be detached for use as the bur	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	5 Other (specify)	1 1 24a. Was	Month  obacco use contribute to  Yes 2□ No 3□ Pontan 24b, Were an	o the cause of death robably 4 Drokr utopsy findings avai completion of cause
is certificate has been signed by the attending physicia director, page 2 should be detached for use as the bur	o Be Completed by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	the underlying cause given in Part I.  26. Place o	24a. Was autoperfc 1   Tensor of Death (Check only control of the	Month  obacco use contribute to Yes 2 No 3 P.  an psy prior to death? 1 Yes one)  dence 6 Other (Spe	Day Year of the cause of death robably 4 Interpretation of cause completion of cause a 2 No
n. After this certificate has been signed by the attending physicia funeral director, page 2 should be detached for use as the but	To Be Completed by Physician/M	23b. Was decedent prequant in the past 12 months? 1   Yes 2   Yes   Yes	the underlying cause given in Part I.  26. Place of patient 3 DOA Other: 4 Nursume of pury Mark Work?  M 1 Yes 2 No.	24a. Was auto perforting Home 5 Resi	Month  obacco use contribute to Yes 2 No 3 P  an 24b. Were an prior to death? 1 Yes one)  dence 6 Other (Spechow injury occurred	Day Year  of the cause of death  robably 4 Introduction of cause  a 2 No  acify)
n. After this certificate has been signed by the attending physicia funeral director, page 2 should be detached for use as the but	To Be Completed by Physician/M	23b. Was decedent premant in the past 12 mynths?  1   Yes 2   Yes   Yes	the underlying cause given in Part I.  26. Place o Datient 3 DOA Other: 4 Nursume of Jury M 1 Yes 2 No.	24a. Was autoperfit   27   28d. Describe   28f. Location (City or To	Month  obacco use contribute to Yes 2 No 3 P  an 24b. Were an prior to death? 2 Ho 1 Yes one)  dence 6 Other (Spe how injury occurred  Street and Number or R wn, State)	Day Year  of the cause of death robably 4 Pronkr  utopsy findings avait completion of cause  a 2 No  ecify)
n. After this certificate has been signed by the attending physicia funeral director, page 2 should be detached for use as the but	Certification: To Be Completed by Physician/M	23b. Was decedent prequent in the past 12 months? 1   Yes 2	the underlying cause given in Part I.  26. Place of patient 3 DOA Other: 4 Nurs Work?  M 1 Yes 2 Nom, street, factory, office	24a. Was auto performed to the performance and due to the performance and	Month  obacco use contribute to the contribute t	Day Year  of the cause of death robably 4 Pronkr  utopsy findings avaicompletion of cause  s 2 No  ecify)  ural Route Number, s stated, e to the cause(s)
rs after death.  ral Director: After this certificate has been signed by the attending physicia lled in by the funeral director, page 2 should be detached for use as the bu	To Be Completed by Physician/M	23b. Was decedent prequent in the past 12 months? 1	the underlying cause given in Part I.  26. Place of patient 3 DOA Other: 4 Nurs Work?  M 1 Yes 2 Nom, street, factory, office	24a. Was auto performed to the control of the contr	Month  obacco use contribute to Yes 2 No 3 P  an 24b. Were an prior to death? 1 Yes one)  dence 6 Other (Spechow injury occurred  Street and Number or Rewn, State)	Day Year  of the cause of death robably 4 Pronkr  utopsy findings avail completion of cause  is 2 No  exify)  ural Route Number is stated. e to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#17perFH, G894, 8/14709, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Howard Levi Binkley 5:55P™ 26, July 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Gilchrist Hospice Towson Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 09/01/1923 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Hours Months Days Min 286-18-1461 85 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Show 10a. State 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examiner mast be notified at Yes 2 No Ellicott City MD Howard Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21043 7715 Briarstone Court Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? US Navy 1 XX Ses 2 No VI 1944–1946 Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Specify: White altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. 2 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Westinghouse Elementary/Secondary (0-12) College (1-4or 5+) Electric Testing Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Binkley Amos Sterling Levi Opal **Binkley** Ε. ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7715 Briarstone Ct., Ellicott City, MD 21034 of Health a item 27 ls Larry Binkley / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages
Department of
Important: If it
any Injury or c 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State Memorial Park Cemetery 8/1/2009 Lima, OH 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Porota Marshall 22. Name and Address of Facility
Charles 1. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 21230 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final OMPLICATION **Physician** vectors disease or condition resulting in death) <sup>1</sup> /Medical Due to (or as a consequence of): BI WE ICAL EXAMINER Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ DIMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? 1 □Yes 2 ☑ No certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examine: 1 Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOTH ( 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 ☐ Pending investigation 1 Natural Fall UNX July 7, 2009 1 ☐ Yes 2 ZNo within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide columbia, MD MINSTER WAY ASSISTED LIVING PACILITY 7110 Hospital Certifier (Check only one)

Certifier (Check only one)

Certifier (Check only one)

Certifier Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifier (Check only one)

C 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar Centles ST

Towson

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(270) N. (2 Registrar's Signature

JOHAL

31. Date filed (Month, Day, Year)

-009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 28 Year 1834 Physician BRUNSHTEYN July 2009 **IOSIF** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Sinai Hospital of Baltimore Baltimore N/A If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
MOLDOVA 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 5. Social Security Number **Funeral** 09/03/1931 Hours 1**X** M 2□ F Months Days Director 217-57-5618 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County 2 should be filed within 72 hours after death with the Marylar and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show raumatic event, it is Marifold Event in the notified as 1X Yes 2 No BALTIMORE Completed by Funeral Director N/A MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21215 3615 FORDS LANE, #208 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1 Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 🏌 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Flementary/Secondary (0-12) DENTISTRY DENTIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BRUNSHTEYN **MOSHE** LAYKA ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau 34 BENSMILL COURT, REISTERSTOWN, MD GARY BRUNSTEIN / SON 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW 07/30/2009 REISTERSTOWN, MD 4☐Donation 5☐Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS.. 21. Signature of Funeral Service Licensee Mett 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final myokerdial tem days **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner few days Mulh-organ system.

Due to (or as a consequence of): Ecqueritally list for cillions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of) Box 68760 Physician/Medical ending purse as t IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? atten for u 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Piabete 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an Hypertensión was a. autopsy performed? icate has l page 2 sl certificate 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After thi 27. Manner of Death 1 Watural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one)

State Registrar

DHMH 17 Rev 1/2001

Isif Brynshleyn

KNOWN 95

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Dawin

Gauvin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sinui Hospital of Baltimore 32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

28 2009

State of Maryland / Department of Health and Mental Hygiene 🔝 🗎 🖠 Certificate of Death Rea. No.

**Physician** /Medical Examiner

**Funeral** 

Director the Maryland show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar in the Item Landland an once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

Examiner

Physician/Medical

IF FEMALE:

burial-transit and attending physician as the t nse for 1 signed by the a peen has

Division of Vital Records, P.O. Box 68760,

law requires that the death certificate be executed 2 Hepatitis B Completed 24a Was an autopsy performed?

1 □ Yes 2 No Hospital or Attending Physician: '24 hours after death.
Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 X Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2. 29c. License number 29b. Signature and title of certifier D0068323 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Indira E. Molai, M.D. 19735 Germantown Road, #100, Germantown, Maryland 20874 31. Date filed (Month, Day, Year) 32. Registrar's Şignature State 31 2009 Registrar DHMH 17 Rev 1/2001

1 - For State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009  $A^{M}$ Min Chou 26 2:55 S11 Ju<sub>1</sub>y 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bethesda Montgomery Suburban Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) November 11, 1930 Birthplace (State or Foreign Country) Hours 1X M 2□ F Months Days 529-60-6510 78 China Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 1 □Yes 2 No Director North Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20852 United States 6104 Rosemont Circle Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 □Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: Asian ≥ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Research Satellite 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Not Available Chih Chou Chao Huai ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 360 Vallejo Drive, #97, Millbrae, California 94030 Danny Chou / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition August 1, 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc 2009 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer Sep Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 ☐ No

Due to (or as a consequence of): Due to (or as a consequence of):

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death

Due to (or as a consequence of):

3 Ectopic pregnancy Pregnant at time of death 5 ☐ Other (specify) 9 Tinknown

Atherosclerotic Heart Disease

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No

Unknown

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year) July 29, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** CARR 2009 LOTTIE MAE TATE U /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner LARKS MEDICAL ATCIVIL ENTER Date of Birth (Month, Day, Year) 12/01/1920 If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Min NORTH CAROLINA 1 ☐ M 2 K F Months Days 88 237-20-6589 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it s Medical Examinar must be notified at 1 □Yes 2 No Funeral Director PENDER WILLARD N.C. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 28478 USA 24525 I.S. HIGHWAY 421 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11. Marital Status should be filed within 72 hours after and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Specify: BLACK 1 ☐ Yes 2X No Be Completed by 31☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HEALTH CARE CERTIFIED NURSING ASST. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) laryland Loonie Newton Eligah Tate, Jr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6912 BRIARCLIFF DR., CLINTON, MD. 20735 of Health a MS. CLEMENTINE V. NEWKIRK Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition MBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If II any injury or conce. 08/03/2009 WILLARD, N.C. NEWTON CEMETERY 81. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final C **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to infine data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed physician and s the burial-trans Box 68760. Physician/Medical law requires that the death certificate attending philor use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) Ö s been signed by the should be detached 9 I Unknown ت 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b autopsy Was case referred to medical examiner? 2 🗹 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 □Yes 2 □No investigation hours after death. 2 Accident within 24 hours after death

To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital t 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00008370 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ACRANEZAV, LA IN IT CHEST, 31. Date filed (Month, Day,

State Registrar

			For State	State	of Marylan	•		lealth and N		0.0	0.0	01.507
-			Registrar  1. Decedent's Name (First, Middle,	(act)		Cer	rtificate of I	Deam	2. Date of Deat	eg. No. /	UD	3. Time of Death
	Physicia	an	Josephine Belle	,	1				July 29	Day	Year	8:15 A <sup>M</sup>
-	/Medic Examin		4a. Facility Name (If not institution,				4b. City, Town, or	Location of Death	Cury 23	4c. County	of Death	0.13 A
	Examin	er	5622 Kallan Cou		,		Arbutu			Ba	ltimo	ore
	Funeral			6. S <i>e</i> x	7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		9. Birth	place (State or Foreign ntry)
	Director		192-14-0060	1 □ M 2 🔽 F	91	Yrs.	monard Bayo		1/6/191	8	Penr	nsylvania
	and		Usual Residence of Decedent  10a, State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	Maryti f sho	힏	MD Balti	more	Ar	butus						1 ☐ Yes 2 🙀 No
	r 28a	Director	10e. Street and Number			Ducub	10f. Zip Code		1	0g. Citizen of	What Cou	ntry?
	h with		5622 Kallan Cou	rt			21227				USA	
	deat	Funeral	11. Marital Status	12. Was Dec Armed F	edent Ever in U.S	S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Pu <i>e</i> rto	ecify Yes or No- Rican, etc.)		e - Ameri	can Indian, etc.
9	hours after death with the Maryland tural", or items 23a or 28a-f show al Examinar must be notified at	by Fu	1 Never Married 2 Marrie	ed 1 ∏Yes If Yes, G	2 <b>X</b> No iive		1 □Yes 2 🛛 No	Specify:		Specif		nite
5-0036	hours tural		3	Year or I	Dates:	16a Dece	dent's Usual Occup	nation		16b. Kind of B		
215	in 72 n "nat	Completed	(Specify only highes	t grade completed		(Give	kind of work done of DO NOT use retired	durina most of work	ting			,
212	filed within Hygiene. other than '	mo.	10 Elementary/Secondary (0-12)	College	(1-4or 5+)	Hom	nemaker			Own	n Hon	ne
밀	e file al Hy I othe vent,	Be (	17. Father's Name (First, Middle, L	ast)				18. Mother's Nam		Maiden Surnar	ne)	
Maryland	should be filed within 72 hours after death with the Marylar and Mental Hyglene. It marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examinat must be notified at	2	Rex Bailey					Rachel				
Jar	2 sh h and h smd fs m	1.5	19a. Informant's Name/Relationsh		nughtor		•	and Number or Ru				
	s 1 and 2 should by Health and Men item 27 is marke other traumatic.		Sandra J. Sande	ISOII / D				ourt, Ark		20c. Location		
Baltimore,			1 ☑ Burial 2 ☐ Cremation		i State	_	sition (Name of matory or other place		1 /2000	T	, D	.11 p
			4 ☐ Depation 5 ☐ Other (Sp. 21. Si riature of Funeral Service L		Gre		Mem. Gd: 2. Name and Addre		1/2009 Jubbard F			
Ba	permit. Departr Imports any inji	. 0	NK. C	Sic	***	4	1107 Wilke					land 21229
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that	caused the death				•			Approximate Interval Between
	Physician	6 1	Immediate Cause (Final disease or condition			ulm	mary	Arre.	st			Onset and Death
: مو:	/Medical		resulting in death)	Due to	or dio po (or as a cons qu	uence of);	, , ,					- in
	Examiner	_	Securitially list conditions	b	main		ion,	Dehyd	ration			t mouths
0	isit	Examiner	Focus tions list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequ		10 0	tiu w	the An	OCEV	10	2- 3ycours
"JR	execut and al-trar	xan	that initiated events resulting in death) Last	c. Due to	ascunsequence (or as a consequence	uence of):			5		- OF	
760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	lical		d (	ereb	ral 1	Jasculo	W ACC	ident.	S		6 years
89	tificat ig phy as the		-			TV .						
Вох	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna		☐ Ectopic pregnanc	CV			ate of deli	
O. E	e dea the at red fo	sici	in the past 12 months? 1 ☐ Yes 2 DtNo		gnant at time of d		Other (specify)	·		101	onth	Day Year
<u>~</u>	nat the de of by the letached	Phy	9 ☐ Unknown  Part II. Other significant condition	ns contributing to	death but not resi	ulting in the u	nderlying cause giv	ven in Part I	23e. Did to	bacco use con	tribute to	the cause of death?
Records,	w requires that s been signed k should be deta	d by							1 □ Y	es 2 <b>1</b> 0	3∏ Pro	obably 4 🗌 Unknown
S	v requ been shoul	Completed	Penal	Insu	fficia				24a. Was a	n 24h	Were au	topsy findings available
æ	: The law cate has	dmo	1 Covere	47.30	X I I I C I C	7	1		autops perform	sy med?	prior to c death?	completion of cause of
ā	sician: The certificate rector, pag		25. Was case referred to medical			- 7	-	26. Place of Dea	1 □Yes th (Check only or	2 No l	1 □ Yes	2 □No
<u>=</u>	ysicia iis cer direct	To Be	examiner? 1 ☐ Yes 2 <b>X6</b> lo	Hospital:	Inpatient 2	ER/Outpatie	nt 3 □ DOA Oth	or:	ome 5 Resid		her <i>(Spec</i>	cify)
0	ng Ph fter th neral	L:uc	27. Manner of Death  1 Natural 5 ☐ Pending	(8.60	e of Injury onth, Day, Year)	28b. Time o Injury	of 28c. Inju Wor	ry at rk?	28d. Describe h	ow injury occu	rred	
Sio	eath. or: A the fu	catio	2 ☐ Accident investig	ation				]Yes 2□No				
Division of Vital	or Atl fter d Sirect in by	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	nod Zee. Flat	ce of Injury - At ho ding, etc. <i>(Specit</i>	ome, farm, sti fy)	reet, factory, office		28f. Location (S City or Tow		ber or Ru	ral Route Number,
	pital ours a eral C		29a. Certifier 1 Certifyin	g Physician: To the	ne best of my kno	wledge, deal	th occurred at the t	ime, date and place	and due to the	cause(s) and n	nanner as	stated.
)	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, to	Medical	(Check only 2 Medical one)	Examiner: On the	basis of examina inner stated.	ation and/or in	nvestigation, in my	opinion, death occu	rred at the time, o	date and place	, and due	to the cause(s)
	To th Within To th	Me	29b. Signature and title of certifier	mi	IA		29c. Licens	se number	2	29d. Date sign	ed (Month	n, Day, Year)
			<b>)</b>	Ti fer	$\mathcal{U}(1)$	MD	D3	3265	1	07/	29	12009
	10		30. Name and address of person	who completed ca	use of death (Iter	n 23a) (Typ <i>e</i> ,	Print)	- 1 1	0:-	(	, ,	11 21032
	Q		John Jer	enitso	J MO	703	s pend	erbrook	e pr.	Crowi	1501	ile, mis
	Sta Registi		JUL 31 200	9 12 100	negistrar s Sigha	back	1					
			200	9		7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical or Location of Death Examiner 0000 Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 26 7. Age (In yrs last birthday) Yrs. **Funeral** Min. 1 XM 2□ F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Everging. The incition at once. 10d. Inside City Limits 10c. City Town or Location 10a 10b. County 1 No 2 No imore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married 1∐Yes 2⊅1⊷ Specify. ≥ 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working , lite DONOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) mi-ma 0 Name (First, Middle, Maiden 17. Father's Name (First, Middle, Last) Be ဥ Informant's Name/Relation 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) Commons 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 21. Signatur of Funeral Service Lizensee 23a. Perfi. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resolutions)

a.

Due to (or as a consequence of): Onset and Death **Physician** /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (o as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 🗌 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Tes 1 🔲 Inpatient 2 ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

**Examiner** or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Box 68760. / the attending pf ched for use as tf P.O. detached þ signed I Records, icate has been si ; page 2 should t After this certificate I funeral director, page Division of Vital

Maryland 21215-0036

Baltimore,

Certification: To

27. Manner of Death 5 Pending investigation 1 Natural 2 Accident

3 Suicide 4 ☐ Homicide

(Check only

29a. Certifier

☐ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certified

29c. License number

9d. Date signed (Month, Day, Year)

State Registrar

Medical

31. Date filed (Month, Day, Year)

and manner stated.

5

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

To the Hospital

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 29, Day 2009 **Physician** MASON CLOGG, JR. 8:13 AM July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Greater Baltimore Medical Center Towson If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) April 25,1916 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Maryland Days Hours **1**√XM 2□ F 93 212-05-6963 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant; If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 ☐ No Baltimore City Funeral Director Maryland Baltimore City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number **USA** 21214 4409 Harcourt Rd. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 | Yes 2 | If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 yrs. College (1-4or 5+) Armco Steel Metallurgist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Wendenberg Mason Clogg, Sr. 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12251 Roundwood Rd. Unit 210 Timonium, Md. 21093 Winifred A. Lembitz (Daughter) Department of Healt Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State 7-31-2009 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Lassahn Funeral Home 21. Signature of Funeral Service Licenses <u>7401 Belair Rd. Baltimore, Md. 21236</u> Approximate Interval Between Qnset and Death 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SCOSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Vrinary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed Due to (or as a consequence of) physician a the burial-Box 68760, Physician/Medical The law requires that the death certificate attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Vear Day 4 Pregnant at time of death 9 Unknown 5 Other (specify) P.O. signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>Ş</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After the Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident neral Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a

To the Funeral [ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number July 30, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Scite 4105 Touson MD 21204 Jason Black 6701 North Charles 31. Date filed (Month, Day, Year) 32. Registrar's Sigrature Registrar

		Please	Type or Prin State of Ma		l / Depa	rtment of H	lealth ar			_	ble.	01.	606
Physicia	an	Registrar  1. Decedent's Name (First, Middle, Last	st)			tificate of I	Death		ate of Death	Day	Year	3. Time of	
/Medic	al	DONNA A		CZAJK	COWSKI		- Landing of I	PUL	Y 2	6 20 4c. County		11:56	A M
Examin	er	4a. Facility Name (If not institution, given FREDERICK MEMOR		ΓAL		4b. City, Town, or FREDERI		Deam		FREDI			
Funeral Director		5. Social Security Number 6. S		e (In yrs. la 90	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (N	ate of Birth Month, Day,		9. Birthp Coun	nlace (State o	r Foreign
yland how		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation					1	0d. Inside Ci	
the Mar r 28a-f s rotified	Funeral Director	MD Frederic	k 	Adams	stown	10f. Zip Code			10	g. Citizen of V	Vhat Cour	1 ☐ Yes	2 <b>N</b> No
ath with	ral D	3200 Baker Circle	,			21710				USA			
filed within 72 hours after death with the Maryland Hygiene. Uther Ithan "natural", or items 23a or 28a-f show ent, the Medical Evaminer must be redified at	by	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Tyes 2 If Yes, Give Year or Dates:			Was Decedent of H f Yes, specify Cuba I □Yes 2	lispanic Origii an, Mexican, I Specify:	n? (Specify Y Puerto Rican	es or No- , etc.)	Blac	e - Americ k, White, o Whi		
ithin 72 hou ne. <b>han "natur</b>	Completed	15. Decedent's Ec (Specify only highest gra	ducation ade completed) College (1-4or 5	i+)	(Give life. L	dent's Usual Occup kind of work done DO NOT use retired 'etary	durina most o	of working		6b. Kind of Bu Federa Governa	a1.	dustry	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If the IZ1 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Co	12 17. Father's Name (First, Middle, Last) Arthur Grover Mar			5001				t, Middle, M	aiden Surnam stophe	ne)		
id 2 shouth and Notes is the second of the s		19a. Informant's Name/Relationship (Norman Czajkowski,				ng Address (Street Baker Ci							
ages 1 an nt of Hea t: If item 2		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Pia ce Ches	ace of Dispo	sition (Name of natory or other place Cremate	ce)	Date /29/20	2	eltsvi	City or To	wn, State	
permit. Pa Departme Important any injury		4 □ Donation 5 □ Other (Specification of Fuheral Service biger		M01539	9 22	Name and Addre	ss of Facility	Rapp F	unera	1 & Cr	emati		es.
Physician /Medical		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	C 11	pal	Do not ent		ng, such as ca					Approximat Interval Bet Onset and	ween
Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Asyst	a conseque	ence of):						1	minu	
e executec	Examiner	that initiated events resulting in death) Last	c. Hypo: Due to (or as	a conseque	ence of):							hour	5
icate be physicia the buri	_	•	d. Myoca	ardi	al I	nfarcti	ion					Days	5
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant a 9  Unknown	2 Fetal	death 3	Ectopic pregnand Other (specify)	÷у		_		te of delive	-	Year
fuires that in signed by	þ	Part II. Other significant conditions of	contributing to death b	ut not resul	ting in the u	nderlying cause giv	en in Part I.			acco use cont			
1: The law rec ficate has bee r, page 2 shoo	Completed								24a. Was ar autops perform I □ Yes 2	ned?	prior to co death?	opsy findings ompletion of c 2 □No	available ause of
rsiciar s certii lirecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 $\square$ F		nt 3 DOA Oth	er.	of Death <i>(Chi</i>		e) nce 6 □Oth	ner (Sneci	f <sub>V</sub> )	
nding Phy tth. :: After thi	Certification: To	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da		28b. Time o Injury	f 28c. Inju		28d. I		w injury occur			
al or Atte s after deg il Director	Sertifica	3 Suicide 6 Could not b 4 Homicide determined	Zoe. Place of III	ury - At hor c. (Specify	me, farm, str	eet, factory, office		28f. L	ocation (Str City or Town	reet and Numb , State)	ber or Run	al Route Nun	nber,
re Hospita n 24 hours ne Funera pletely fille	Medical C		hysician: To the best miner: On the basis of and manner st	of examinati									s)
To the within to the comp	Me	29b. Signature and title of gertifier	ld.			29c. Licens	se number (689°)	77	25	9d. Date signe			
10			completed cause of c	death (Item	23a) (Type,	Print) 7th S	t. Fr	reder	ick				
Sta		31. Date filed (Month, Day, Year)	32. Registr	rar's Signati	ure	/							
HMH 17 Rev 1/2	JUL 3 1 2009 Jensey S. Sparles												

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2009

	Physici /Medic		Clayton B. Culle	n		Month D	) Zw9 /245 M
	Examir		4a. Facility Name (If not institution, give street Season's Hospic	· · · · · · · · · · · · · · · · · · ·	4b. City, Town, or Location of Dea		c. County of Death Baltimore
	Funeral Director		5. Social Security Number 6. Sex 123-12-7671	7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hr Months Days Hours Mir	8. Date of Birth	9. Birthplace (State or Foreign Country)
	Maryland a-f show	ctor	Usual Residence of Decedent  10a. State	10c. City, Town or Lo	cation Randall		10d. Inside City Limits 1 ဩ∀es 2 □ No
	with the 3a or 28 If build	al Director	10e. Street and Number 47 Millstone F	load	10f. Zip Code 21133	10g. C	Citizen of What Country? USA
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercitar runst be notified at Once.	by Funeral	1 Never Married 2 Married 1	as Decedent Ever in U.S. med Forces?  **Tes 2	Was Decedent of Hispanic Origin? ( f Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21	filed within 72 how Hygiene. Ither than "natura ent, the Medicel I	Completed		pleted) 16a. Deced (Give life. I	ent's Usual Occupation kind of work done during most of w OO NOT use retired) Salesman	orking	Kind of Business/Industry  fice Equipment
Maryland 21	should be filed vand Mental Hygic s marked other umatic event, II	To Be Co	12 17. Father's Name (First, Middle, Last) Max Culler	2		ame (First, Middle, Maide	en Surname)
Mary	nd 2 shou lith and M 27 is ma		19a. Informant's Name/Relationship (Type. Proceedings) Clayton Michael C		ng Address (Street and Number or I		
Baltimore,	Pages 1 and 2 ment of Health ant: If item 27 i ury or other tra		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo	sition (Name of natory or other place)	Date 20c.	Location - City or Town, State anover, MD
Balt	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee	uskal	Name and Address of Facility Maryland Crema PO Box 1413, J	ation Serv	vices MD 21203
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau immediate Cause (Final disease or condition resulting in death)	ns that caused the death. Do not ent use on pach line.	er the mode of dying, such as cardi	ac or respiratory arrest,	Approximate Interval Between Onset and Death
68760,	death certificate be executed e attending physician and dor use as the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to inned a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):			
. Box	the death certifica y the attending phi ched for use as th	Physician/Medical	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
rds, P.	w requires that the de been signed by the should be detached t	þ	Part II. Other significant conditions contribut	ing to death but not resulting in the u	nderlying cause given in Part I.		o use contribute to the cause of death? 2□ No 3□ Probably 4★ Unknown
Vital Records,	The larate has	Completed				24a. Was an autopsy performed? 1 ∐Yes 2 <b>2</b>	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ▼No
Vita	ysiclan: The	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 N No Hospit	al; 1 ☐ Inpatient 2 ☐ ER/Outpatier	Other	eath (Check only one)  Home 5 T Residence	6 DOther (Specify) Season's Hospic
ion of	anding Phy anh. r. After thi	ation: To	27. Manner of Death 1 1 Natural 5 □ Pending 2 □ Accident investigation	a. Date of Injury 28b. Time o (Month, Day, Year) Injury		28d. Describe how in	
Division	To the Hospital or Attendin within 24 hours arer death. To the Funeral Director Af completely filled in by the fur	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28	e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	e Hosp 24 hou e Fune detely fil	Medical	(Check only 2 Medical Examiner: (	<ul> <li>To the best of my knowledge, deat on the basis of examination and/or in and manner stated.</li> </ul>			
	To th within To th	Me	29b. Signature and title of certifier  **LULLULUSU  **LULLUSU  **LUL	ılın	29c. License number 14 459 3/		Date signed (Month, Day, Year) $07/3v/v$
	Sta	te.	30. Name and address of person who comple properties 1 31. Date filed (Month, Day, Year)	ted cause of death (Item 23a) (Type, 2835 32. Registrar's Signature	Print) Avenue	BH Himore	MD 21209
	Sta	ite		a Museum B. 7	Charles and		

DHMH 17 Rev 1/2001

1 - For State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JULY 28, 2009 08:30 COHEN LUCILLE 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **HOWARD** COLUMBIA VANTAGE HOUSE NURSING HOME Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 10-06-1923 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number Days Hours Months 1 □ M 2 X F NY 85 104-16-2233 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 No COLUMBIA MD **HOWARD** 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number USA 21044 5400 VANTAGE POINT ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 No Specify WHITE 3 X Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) EDUCATION **TEACHER** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MITTLEPUNKT COHEN MAX 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 200 CATHCART ROAD, GWYNEDD VALLEY, PA 19437 RENEE FLEISHER/DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State ELMONT, NY 07-30-2009 BETH DAVID 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (r as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury presi that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Year 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 MNo 9 ☐ Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2√Z No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of 27. Manner of Death 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner

Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

**Physician** 

/Medical

**Examiner** 

**Funeral** 

**Director** 

ral", or items 23a or 28a-f show Examiner must be notified at

"natural"

l and Mental hygren... I is marked other than "nature

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Department of IImportant: If ite
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death with the Maryland

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

requires that the death certificate be executed use as the burial-transi and attending physician of the burial detached ed by sign. page 2 certificate To the Hospital or Attending Physician: director this After thi

P.O. Box 68760,

of Vital Records,

Division

death. filled in by the fu

within 24 hours after To the Funeral Dire

6 ☐ Could not be

5 Pending investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

3 Suicide 4 Homicide

> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
>
> | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 31

Registrar's Signatus

Registrar DHMH 17 Rev 1/2001

State

09-05911	.ro	Please Type	e or Print in Bi te of Maryland	/ Denai	tment o	nk. Ensu f Health a	nd Ment	al Hva	iene	Die.		
Paula Jean Decle		State 1- For State	te or iviaryianu		tificate o		ila iviori		Reg	. No. 2	009 2460	
Physicia		Registrar 1. Decedent's Name (First, Middle,	Last)					2.	Date of Death		3. Time of Death	
Medical Examin		Paula Jean de	Clercq						Month [ July 28, 200		12301115	
		4a. Facility Name (if not institution,	give street and number	)		4b. City, Town, Bel Air	or Location o	of Death		4c. County of Harford	Death	
		Upper Chesapeake Me		je (in yrs. la	ot hiethday/	If Under 1 Ye	ear Lif Linde	er 24Hrs. 8	B. Date of Birth	(MM/DD/YYYY)	9. Birthplace (State or	
Funeral Director	1	015 11 6007		39		Months Da	ays Hours		07/05/1	`	Foreign CountryMaryland	
Birector		Usual Residence of Decedent	1 M 2X F		Yr	S.						
any	Ì	10a. State 10b. County		10c. City,	Town or Loca	ation					10d. Inside City Limits	
*	٦	MD Harfo	rd		Baltin	nore		_			1 XYes 2 No	
Aaryla 28a-f	Director	10e. Street and Number	D 1 A-4	T.		10f. Zip Code 2101			100	U.S.A.	at Country?	
vith the Maryland 2.23a or 28a-f show a 2.00iffed at once.		956 Pentwood							if Var at No		- American Indian, Black,	
th with ems 2	Funeral	<ul><li>11. Marital Status</li><li>1 Never Married 2 X Mar</li></ul>	12. Was Deceden	?	S. 13. W	as Decedent of Yes, specify Cub	Hispanic Orig an, Mexican	, Puerto Ri	can, etc.)	White,		
er dea			1 Yes 2	X No	1	Yes 2 X	No specify:			Specify:	White	
hours afte	d by	15. Decedent's Education (Speci	or Dates:	mpleted)	16a. Decede	ent's Usual Occu	pation (Give	kind of wor		16b. Kind of Bus	iness/Industry	
72 ho	ete	Elementary/Secondary (0-12)	College (1-4 or	5+)		most of working	ille. DO NOT	use remed	''	0 11		
5-0036 iled within 72 Hygiene I other than '	Completed		2		Hor	nemaker	19 Mothor	r'o Namo (E	irst Middle M	Own Ho		
15-C								ner's Name (First, Middle, Maiden Surname) eryl Parrack				
21215-0C hould be filed with and Mental Hygien is marked other rife event, the M	0	19a. Informant's Name/Relationsh	ip (Type, Print )		19b. Maili	ing Address (St				per, City or Town	n, State, Zip Code)	
AD 2 show the and 27 is amatin	-	Vernon deCler	cq/Husband		9.	56 Pentw	rood Re	oad,A	pt.F, I	Bel Air,	, MD 21014 City or Town, State	
imore, MD 2121. Pages I and 2 should be filment of Health and Mental I tant: If item 27 is marked or other traumatic event.		20a. Method of Disposition  1 Burial 2 X Cremation	3 Removal from S	20b. F	Place of Disp crematory or	osition (Name of other place) Mation Set	cemetery,				r, Maryland	
Pages Pages ant: I		4 Donation 5 Other Sp.		Ard				1				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service I	icensee	0119-	7 22	Name and Addr	ess of Facilit	y Ard	ent cre	emation N Hanc	Services over, MD 21076	
		Zaura C. Har. 23a. Part I. Enter the disease, or			Do not ente	The mode of dyi	ng, such as	DLTV cardiac or r	espiratory arre	st, shock, or hea	art Approximate Interval	
Physician Medical		failure. List only one cause	on each line. a. Pulmonary Thi								Between Onset and Death	
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	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a con	sequence o	f):							
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0, be ex	edic	UNPENDED	AMENDED							23d. Date of	f delivery	
Records, P.O. Box 68760, The law requires that the death certificate be care has been signed by the attending physicipage 2 should be detached for use as the burn	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in th	e 23c. If yes, outc	ome of preg	nancy 2	Fetal death	3 Ectop	ic pregnan	су	Month	Day Year	
ox 6	sicia	past 12 months?  1 Yes 2 No 9 ✓ Unk		at time of de	eath 5	Other (Specify)						
Bc he dea y the a hed fc	hys	Part II. Other significant conditi	a Guidiowii	ath hut not r	resulting in th	e underlying cau	ise given in F	Part I.	23e. Did to	bacco use contr	ribute to the cause of death?	
Division of Vital Records, P.O. B rat or Attending Physician: The law requires that the d rs after death.  **I Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached	by	ratin other signmount conduc	one contributing to de			, ,			1 Yes	2 No 3	Probably 4 V Unknown	
ds, equire een sig	Completed								24a. Was		Were autopsy findings available prior to completion of cause of	
COF law r e has b e 2 she	mple	() <del></del>				·		<del></del> -		rmed?	death?  ✓ Yes 2 No	
<u> </u>		25. Was case referred to medica		<del></del>		26.P	lace of Deat	h (Check o		2		
/ital rsiciar nis cerr directo	o Be	examiner? 1 ✓ Yes 2 No	11.1	itient 2	ER/Outpati	ent 3 DOA	Other <sub>4</sub>	Nursing	Home 5	Residence 6	Other:	
of \ og Pluy (fter the	-	27. Manner of Death	28a. Date of I	njury v,Year)	28b. Time	· ' '   .	Injury at Wo		28d. Describe	how injury occur	red	
ion tendin eath. for: A	atio	1 Natural 5 Pend 2 Accident Inves	ding				Yes 2			S. ( ) 11	Dural Davida Number City	
ivis or At after d Direct I in by	Certification:	3 Suicide 6 Coul	d not be 28e. Place of	Injury - At h	nome, farm, s	treet, factory, off	ice building,	etc.	28f. Location ( or Town, S		per or Rural Route Number, City	
Division of Vital Hospital or Attending Physician: 94 hours after death. Finneral Director: After this certifiely filled in by the funeral director.	Se	4 Homicide	rmined (Specify) hysician: To the best of		de a de abb e a	sourced at the tim	e date and r	place and	due to the caus	se(s) and manne	er as stated.	
	Medical	(Check only 1 Certifying Plone) 2 Medical Exa	miner: On the basis of e	xamination	and/or invest	igation, in my opi	inion, death	occurred at	the time, date	and place, and	due to the cause(s)	
To the within. To the comple	Med	29b. Signature and title of certifie	and manner state	ea			cense numbe				ned (Month, Day, Year)	
		In meets Douts	all MI			0	.C.M.E.			July 29, 20	009	
1.		30. Name and address of person							ID 04004			
Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201												
State 31. Date filed (Month, Day, Year) 32 Registrar's Signature Registrar  31. Date filed (Month, Day, Year) 32 Registrar's Signature												

ORIGINAL

			for State	State of Maryla				Mental Hygie	ene	01 (01	
			1 State Registrar  1. Decedent's Name (First, Middle, Last)		Cer	tificate of L	ficate of Death		3. No.2 [] [] 9		
	Physici	an	Kristen	/	De	Luces	45	2. Date of Death Month	Day Year	3. Time of Death	
	/Medic		4a. Facility Name (If not institution, give	street and number)			Location of Death	July 3	4c. County of Death	10.181	
			The Johns Hopkins He			Baltimore					
100	Funeral Director		5. Social Security Number 6. Se 593-09-0396	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 8/6/1976	9. Birth Cour Fle	place (State or Foreign htry) Orida	
Maryland 21215-0036	tand ow t	ctor	Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits	
	e Mary 3a-f sh ified a		MD Anne Art	undel So	evern					1 ☐ Yes 2X No	
	eath with the ns 23a or 28 must be noti	Funeral Director	10e. Street and Number  1838 Cedar Drive						g. Citizen of What Cou	ntry?	
		era	11. Marital Status	12. Was Decedent Ever in U	18 13			pecify Ves or No-	U.S.A.	con Indian	
	urs after d al", or iter Examiner	by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 XNo	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Black, White, Specify: Whi	etc.	
	72 ho "natura dical E	eted	15. Decedent's Ed (Specify only highest grad		(Give	dent's Usual Occup	during most of work	king 16	6b. Kind of Business/li	ndustry	
2121	and man	To Be Completed	Elementary/Secondary (0-12)	College (1-4 or 5+) 5		DO NOT use retired gineer	")		Governmen	t	
nd			17. Father's Name (First, Middle, Last)					ne (First, Middle, Ma			
Z			David Lance Cooper  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						0.11		
			Keith Deweese/ H		1838			severn, MI		o Code)	
w	es 1 and 2 of Health f item 27 r other tra		20a. Method of Disposition  1  Burial 2  Cremation 3	20b.	Place of Dispo	osition (Name of matory or other place			c. Location - City or T	own, State	
Ĕ	. Pages Iment of I tant: If its jury or o		4 X Donation 5 ☐ Other (Specify	Ar	natony Gi	ifts Regist	ry   7/3		Hanover, M		
Ra	permit. Pages Department of Important: If it any injury or conce.		21. Signature of Funeral Service Licens	ee					fts Regist Hanover, M		
	1000	1	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the dea						Approximate Interval Between	
	hysician /Medical Examiner	iner	Immediate Cause (Final disease or condition Conset and Death								
			resulting in death)								
			Sequentially list conditions, if any, leading to financiate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conse	atic lystadenocarcinoms of live						
i	be executed ician and burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last								
,60,	ate be executed hysician and the burial-transit	dical E	resulting in death) Last  Due to (or as a consequence of):								
200	0 0 0			u			•				
	death e atten ed for u	ian/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fe	al death 3	Ectopic pregnanc	y		23d. Date of delive	ery Day Year	
		Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Onknown	death 5 Other (specify)							
cords, P.O.	signed by	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did toba	23e. Did tobacco use contribute to the cause of death?		
	w require been sig							1 🗆 Yes	1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown		
SP.	To the hospital or Attending Inysterain: The law in 24 hours after death.  To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 st	Completed						24a. Was an autopsy performe	prior to c	opsy findings available ompletion of cause of	
OT VITA		Be Co	25. Was case referred to medical	<u>.                                    </u>		<u> </u>	26. Place of Death	1  Yes 2 (	1 ☐ Yes	2 No	
		P B	examiner? 1  Yes 2 Ao	Hospital: 1 Impatient 2	onital:						
			27. Manner of Death  1  Natural 5  Pending  2  Accident investigation	28a. Date of Injury (Month, Day Year)  28b. Time of Work?  Injury  M 1 □ Yes 2 □ No			28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number, City or Town, State)				
		ertification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	t home, farm, street, factory, office							
5		Cert		ify)							
		Medical	29a. Certifier (check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
		Me	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)								
6			1 par				MES-000 July 27,2009				
			30. Name and address of person who of Keiko Greenbe	110	em 23a) (Type,	Print)	600 1	North Walf-	St Daltima	re, MD, 21287	
	Sta		31. Date filed (Month Day, Year)	32. Registrar's Sign	ature		300 1	NOI WOILE	JI, DAILIIIIO	16, IVID, 21201	
	Regietr			and My	la .	/					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month JULY **Physician** 2009 28 3:30P M BARBARA ANN DeVOE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GILCHRIST CENTER TOWSON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 20, 1936 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 219-32-7742 1 M 2 YF Maryland 73 Director Usual Residence of Decedent 10d, Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinations to ust be notified at 1 ☐ Yes XX No Baltimore Director Maryland Baltimore County 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code death with 21236 USA 5109 Thomas Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or ite 1 ☐ Never Married 2 Married 1 □Yes ŽNo Baltimore, Maryland 21215-0036 Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 yrs. Housewife Housekeeping-Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Michael Feiler Dorothy Minnick ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is rr any injury or other traumonce. John M. DeVoe, Sr. (Husband) 5109 Thomas AVenue Baltimore, Maryland 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Metro Crematory, Inc. 8-1-2009 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signan re of Funeral Service Licensee 22 Larses at 1997 Puffer al Home 7401 Belair Rd. Baltimore, Md. 21236 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Metasmore **Physician** Month disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit P.O. Box 68760, d resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 tensive 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2/2 No 2 □ No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1/ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

BARBARA DEVOE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signa

2009

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** July 29,2009 10:15 Lillian Kathleen Farrell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Bel<u> Harford</u> If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months 1 ☐ M 2 ☐XF Director May 25,1923 220-18-8990 west Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it. It. Alcales Evant incr., ust be notified at 10d, Inside City Limits 10c. City, Town or Location 10a. State 10h. County 1 ☐ Yes 2 No Funeral Director Harford Md. Bel Air 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21015 USA 1310 W. Sheridan Pl. Apt.101 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Clerical 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ivory Pet try James Massey ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1310 W. Sheridan Pl. Unit 302 Bel Air, Md. 21015 DTR. Karen Foster 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-3-2009 Bayview Baltimore City 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 610 W. Mac Phail Rd. BelAir, Md. 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Electromechanical 30 minuto **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): 68760, Physician/Medical Box ( IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 st autopsy performed? Yes 221No 1 ☐Yes 2 ☐ No 1 ☐ Yes After this certification funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 20056607 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
TESEPH ANGLE # 2 .5 . 662 #205, 602 S. ATWOOD Ad, BEL ASK MD 21012 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 6:00 PM **Physician** 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Brightwood 21time If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Social Security Number Year) 30, 1927 **Funeral** Country) Mary Months Days Hours Min. 219-22-3674 1 □ M 2 🔽 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinating the profiled at 1 Nes 2 No Director altimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2120 htwood Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 100 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ 140 Specify: Black Specify: ò 3 Nidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19a. Informant's Name/Relationship (Type. Print) ,daughter MD Department of Heali Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 7/2009 temorial 4 Donation 5 Other (Specify) 21. Signature Aneral Service License -wxer tonce\_ Heights Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiactor respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** inknown disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed this certificate has been signed by the attending physician and al director, page 2 should be detached for use as the burial-transi Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical IF FEMALE: ves, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1□Yes 2XNo 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 4 ☐ Unknown 1 Tes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? 1 ☐ Yes 2 X No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 24 hours after death.

Funeral Director: After the etely filled in by the funeral 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

| Medical Examiner: On the basis of examination and/or investination, in my oninion, death occurred at the time, date and place, and due to the 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely the within To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

Year)

3 1 2009

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2 Day **Physician** 5:15 PM Ford Jul 2009 Bryant /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Secours - Baltimore Bultimore 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min 2□ F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show way Injury or other traumatic event, if a Modical Era ring runs be notified at once. 10d. Inside City-Limits 10b. County 10c. City, Town or Location 10a. State 1 Dres 2 □ No Director Marylan 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 10 11. Marital Status 1 Yes 2 lates: 1 ☐ Hever Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 █ No Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2121. 19a. Informant's Name/Relationship (Type. Print) SISTE 20c. Location - City or Town. 20b. Place of Disposition (Na cemetery, crematory or Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License App ximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final hours **Physician** disease or condition resulting in death) /Medical Due to (\*r as a consequence of): respiratory Examiner دعه و سا Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit To the Hospital or AttendIng Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760p Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 25 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nis certificate has director, page 2 s autopsy performe 1 ☐ Yes 2 No 1 ☐Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this c funeral dire Certification: To 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe DY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2

State Registrar 31. Date filed (Month, Day, Year)



2000 W.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8:53 TULY 2009 John W. Farrish, Jr. /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner timore er 1 Year If Under 24 Hrs. N/A 8. Date of Birth (Month, Day, Year)

Jul. 15, 1 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**X** M 2□ F 56 Maryland **Director** 215-58-1072 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show d 2 should be filed within 72 hours after death with the Maryla thand Mental Hyglene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be retified at 1 □ Yes 2 No Director **Baltimore** Baltimore MD 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21227 United States 1109 Oakland Terrace Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates: Black, White, etc. 1 ☐ Never Married 2X Married Specify: White 1 □Yes 2X No Specify: ⋛ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Dental Practice Dentist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stella Rose John W. Farrish, Sr. ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n any injury or other traunonce. 1109 Oakland Terrace Road, Baltimore, MD 21227 Eileen Farrish - Wife 20b. Place of Disposition (Name of Readlery, Tematory acother place)
Park

Park 20c. Location - City or Town, State Date 20a Method of Disposition Burial 2 Cremation 3 Removal from State 4 Oppration 5 Other (Specify) 7-30-2009 Elkridge, MD a una Fortansi S 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, of compilications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION **Physician** hour /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of if any, leading to firmedic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☐No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only and manner stated.

State Registrar

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altimore, Maryland 21215-0036

- OV (でられ ) OOO! Division of Vital Records, P.O. Box 68760,

HARLES 31. Date filed (Month, Day, Year)

29b. Signature and title of pertifier

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

CURTIS



GNOS HOSPITME BARTIMENE MD

D0051865

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1:00 P M JULY 28 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE PIKESVILLE STONEHENGE CIRCLE #4 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay) (Par) 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Social Security Number **Funeral** 1 ☐ M 2 🗶 F Months Days Hours 217-32-8949 100 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examination is notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 □Yes 2 No Directo BALTIMORE MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21208 USA 25 STONEHENGE CIRCLE #4 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE altimore, Maryland 21215-0036 þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWNER TEXTILES 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be ISAAC YANIGER BAILA FISHBONE ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) NELSON I FISHMAN / SON 1807 SOUTH ROAD, BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BETH TFILOH 07/30/2009 | BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Myochenial INFORCED /Medical Due to (or as a consequence of): Examiner Frilon PHRIV Sequentially list conditions, if any localing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran-Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year in the past 12 months? 1 □ Yes 2 No 5 Other (specify) cate has been signed by the page 2 should be detached 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed' 1 ☐Yes 2 ☐No 1 □Yes 2 No 25. Was case referred to medical examiner? completely filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 1 Natural 2 Accident 5 Pending 1 ☐ Yes investigation Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \ Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ٥ 16

Registrar

State

Botho Md

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Amount D Collburn 2435 Sm

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#8perfH, 6894,8/11/09, WS
State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 07 27 8:12a.M 2009 Gwynn Sr. Forest 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore 2736 West Mosher Street | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | North | Days | Hours | Min. | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex 1√2 M 2□ F Months 85 220-14-7235 NC Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10h County 1 XYes 2 □ No Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21216 2736 West Mosher Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married Married 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore National Elementary/Secondary (0-12) College (1-4or 5+) Groundsman 8th grade Cemetery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ollie Flossie Willis William Henry Gwynn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2736 West Mosher Street, Baltimore, Md 21215 Nannie Bell Gwynn-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, Md Garrison Forest Vet 8/3/09 22. Name and Address of Facility
March F/H West
4300 Wabash Av relof Funeral Service Licensee Baltimore, Md 21215 Ave, 23a. Part 1. Enter the disease, or complications that siflock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death aused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, THEroscherotac Carpionano nevous Due to (or as a consequence of) turetusion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 1 ☐ Yes 2: No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide

/Medical Examiner Box 68760 P.0. Division of Vital Records,

sician and burial-transit Physician: The law requires that the death certificate be executed attending physician for use as the buria signed by the a as been si has certificate ha funeral director, After this To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Baltimore, Maryland 21215-0036

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Director

Funeral

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DHMH 17 Rev 1/2001

State Registrar

Saly 31. Date filed (Month, Day, Year)

30. Name and address of pe

29b. Signature and title of certifier

29a. Certifier

(Check only one)

(082 32. Registrar's Signature

and manner stated

who completed cause of death (Item 23a) (Type, Print) Delle Artenia

1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

DOUS 905

29d. Date signed (Month, Day, Year)

21215 50

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State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 7:15 P M Ernest Melvin Gunter Jul 22, 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard **Ellicott City** 12265 Frederick Rd 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 1 M 2 ☐ F **Funeral** Days Months Hours Director W. VA 68 236-60-5617 Nov 22, 1940 Usual Residence of Decedent 10d. Inside City Limits 10a State 10h. County 10c. City. Town or Location show Department of Health and Mental Hygiene. mportant: filtem 23a or 28a-f shov mportant: if Item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, If a Medical Exacting the restilled at 1 ☐ Yes 2 ☑ No Director **Ellicott City** MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12265 Frederick Rd. 21042 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 | Yes 2 | No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 □Mo Specify. Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Director Supervisory 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rebecca Jane Smith ပ Miley Gunter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Beth Gunter Spouse 12265 Frederick Rd. Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jul 24, 2009 Sykesville, Maryland All County Cremation Services, Signature | Funeral Se Toe L censue 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Soter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CAPDIOUMULTUR Physician しわりらい /Medical Due to (or as a consequence of): Examiner tonto Aningzm Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hy certenjun burial-trai Due to (or as a donsequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 D Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Ye er Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 2 No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 1 □ Yes → No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t 5 Pending investigation 1 Natural To the most after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records,

with the Maryland

death v

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) State Registrar

29a. Certifier

(Check only

29b. Signature and title of certifie



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Partifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 07-27-2009 George Howard Hofherr /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Upper Chesapeake Medical Center Bel Air Harford Birthplace (State or Foreign Country)
 MD 8. Date of Birth (Month, Day, Year) 11–11–1935 If Under 1 Year If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Months 1**X** M 2 □ F 73 Director 213-32-1900 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d Inside City Limits 10c. City, Town or Location 10a State 10b. County d other than "natural", or Items 23a or 28a-f show event, It e Medical Examitrating to confind at 1 ☐ Yes 2 🛣 No Director MD Harford Abingdon 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 911 Towson Dr 21009 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 ⊠ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, If a Me Jit once. Elementary/Secondary (0-12) College (1-4or 5+) Small Business Owner Percision Tune 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Hofherr ပ Evelyn Frisch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3732 Wolf Trail Dr William Hofherr (Son) Abingdon, MD 21009 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BelAir Mem. Gardens | 07-31-2009 | Bel Air, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune 5 rvice Licens 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc. 610 W. MacPhail Rd Bel Air, MD 21014 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or Ma consequence of): minuto /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): be executed P.O. Box 68760, 87 Due to (or as a consequence of) physician a sthe burial-1 Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy Month in the past 12 months? Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has t autopsy performed? 1 Yes 2 No certificate I 25. Was case refailed to medical examiner? 2 No 1 ☐ Yes To the Hospital or Attending Physician: director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this of funeral dire 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2009 10037078

State Registrar

DHMH 17 Rev 1/2001

32.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C. SHAUCHNESSY

31. Date filed (Month, Day, Year)

nessu

egistrar's Signature

104 PLUMTRER Rd STE.115

MD

BEL ALR,

Registrar

Maryland

Baltimore,

P.O. Box 68760,2

Division of Vital Records,

State

5601 LOCH RAVEN BLVD, BALTIMORE, MD 21239.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NARAYANAN

32. Registrar's Signature

SHIVAKUMAR

31. Date filed (Month, Day, Year)

09-05738 Avan'T Harris

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		- For State	i wa yana i	Certificate	of	Death		, ,		eg. <b>N</b> o		
Physicia	n/	<ol> <li>Decedent's Name (First, Middle,Last)</li> </ol>							Date of Dea Month		Year	3. Time of Death 1054 hrs
ledical Examir		Avan't Jai'hean							Month July 23, 2			
		4a. Facility Name (if not institution, give	street and number)		4	b. City, Town, or	Location of I	Death		4C.	County of Deat	.n
		Johns Hopkins Hospital				Baltimore						11 1 2 10 10 10 10 10 10 10 10 10 10 10 10 10
Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday	()	If Under 1 Year Months Day		24Hrs. Min.	8. Date of Bil	rth(MM/D	D/YYYY) 9. Bi Forei	rthplace (State or gn
Director		220-83-4274 *x	M 2 F		Yrs.	4	'S Hours	IVIII I.	March	. 5	200°	ountry) MD
		Usual Residence of Decedent							mar or		2005	
any		10a. State 10b. County		I0c. City, Town or L	ocatio	on						10d. Inside City Limits
<b>.</b> .	_ 1	Maryland N/A		Balt	i m	ore						1 Yes 2 No
nrylar	윉	10e. Street and Number				10f. Zip Code			1	l 0g. Citiz	en of What Co	untry?
e Ma or 28	Ë					2121	3				USA	
0036 within 72 hours after death with the Maryland siene. rec than "natural", or items 23a or 28a-f show Medical Examiner must be notified at once.	Funeral Director	612 N. Milton	Avenue 12. Was Decedent B	verin U.S. 113	. Was	s Decedent of Hi		n? (Spec	cify Yes or No	)- '		rican Indian, Black,
ath w	ner	1 Never Married 2 Married	Armed Forces?	_	If Ye	es, specify Cuba	n, Mexican, F	Puerto R	ican, etc.)		White, etc.	
er de		3 Widowed 4 Divorced	1 Yes 2 If Yes, Give Year	X No 1		Yes 2 X No	specify:			5	Specify: B.	lack
rs afl ural'	화	15. Decedent's Education (Specify onl	or Dates:	oleted) 16a. Dec	edent	t's Lisual Occupa	ation (Give kir	nd of wo	rk done	16b. Ki	ind of Business	s/Industry
2 hou	활	Elementary/Secondary (0-12)	College (1-4 or 5	duri	ng mo	ost of working life	e. DO NOT us	se retire	d)			
36 hin 7 than	희											
5-0036 iled within 72 hou Hygiene. 1 other than "natt	Completed by	17. Father's Name (First, Middle, Last)					18.Mother's	Name (I	First, Middle,	Maiden	Surname)	
e file al Hy	Be	Shawn Harris					Mark	ita	Moor	·e		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		19a. Informant's Name/Relationship (Ty	rpe, Print )	19b. M	lailing	Address (Stre	et and Numb	er or Ru	ral Route Nu	mber, Cit	ty or Town, Sta	te, Zip Code)
sho sho	7	Shawn Harris/	Father	1 1	61	2 N M	ilton	Δτ	eniie	Ra 1	timore	MD 21213
e, M 1 and 2 Health ritem 2	ŀ	20a. Method of Disposition	- 4.0.101				emetery,	0/7	Date / 0 9	20c. L	ocation - City	MD 21213 or Town, State
Ore ges 1 t of F		1 X Burial 2 Cremation 3	Removal from Sta	erematory Arbutu:					/09	122	hutua	Maryland
timen trans		4 Donation 5 Other Specify: 21. Signature of Funeral Secret Licens								IAL.	bucus,	Maryland
Baltimore, permit Pages 1 a Department of He Important: If ite injury or other t		21. Si porture di Funeral Service Licens	ee	- 1		40 D = -	_ 1	Cha	tman-	Har	ris Fu	neral Home
	4	29a. Part I. Enter the disease, or compl	ications that caused t	the death. Do not el	o Z	4U KE1:	STERS a. such as car	rdiac or	n Ra respiratory ar	rest, sho	Clmore ick, or heart	MD 21215 Approximate Interval
Physician /Medical		failure. List only one cause on each	ch line.									Between Onset and Death
xaminer	Ì		Sudden un		d d	leath in	intar	ncy		_		
- 2		or condition resulting in death)	Due to (or as a conse	quence or):								
	ᇣ	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quence of):	_							
	Examiner	cause. Enter Underlying Cause										2
Bx _ =	xar	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):								
760, crate be executed physician and the burial - transit		d										<del> </del>
e exe	Medical	X UNPENDED	AMENDED 23a.	27,28a-f	. ne	erME. g8	97 11/	/19/	09 TT			
'60, cate be physici he buri	§	IF FEMALE:	23c. If yes, outcom		,,,						d. Date of deliv	
687 ertific ding e as t	au/	past 12 months?	1 Live birth	time of death 5			Ectopic	pregnan	icy		Month	Day Year
Box 68 e death certifi	sic	1 Yes 2 No 9 Unknown		time of death 5	Ot	ther (Specify)						
5.0. B. that the de ned by the detached i	Physician	Part II. Other significant conditions		but not resulting in	the i	underlying cause	aiven in Par	rt I.	23e. Did	tobacco	use contribute	to the cause of death?
ires that is signed by the detail		Turk in Other organization	oonang to coun						1 Y	es 2	No 3 P	robably 4 🗸 Unknown
S, F puires an sig	Completed by								24a. Wa	s an	I 24b, Were	autopsy findings available
w rec	Be								auto	opsy formed?		o completion of cause of
ecc he la ate ha	E									2 N		
II R m: 1 rtific tor, p	C	25. Was case referred to medical				26.Pla	ce of Death (	Check o	nly one)			
/ita /sicia /sicia direc	o Be	examiner? 1 ✓ Yes 2 No	lospital: 1 🗸 Inpatie	nt 2 ER/Outp	atient	t 3 DOA	Other <sub>4</sub>	Nursing	Home 5	Reside	ence 6 Ot	her:
of v g Phy fiter ti	<u>۲</u>	27. Manner of Death	28a. Date of Inju (Month, Day,Y	ry 28b. Tim	ne of I	Injury 28c. In	jury at Work?	?	28d. Describ	e how inj	ury occurred	
on ath.	흕	1 Natural 5 Pending	Ed 7/10	. IFa a	pp,	rox.	Yes 2 X	No	unk			
rision Atternation	ica	2 Accident Investigation 3 Suicide 6 X Could not	28e Place of in	jury - At home, farm			building, etc	c.	28f. Location	(Street a	and Number or	Rural Route Number City
Division of Vital Records, P.O. tal or stending Physician: The law requires that the rs after death.  "I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	Certification:	Suicide 6 X Could not determined	(Specify)	residen	ce			- 1	or Lown.	. Siarei		re. Baltimore
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	ŏ	29a. Certifier	an: To the best of m	y knowledge, death	occu	rred at the time,	date and pla	ce, and	due to the ca	use(s) ar	nd manner as s	tated.
the J hin 2 the I	Medical	one) 2 Medical Examiner	:On the basis of exa	mination and/or inve	estiga	ition, in my opini	on, death occ	curred at	the time, da	te and pla	ace, and due to	the cause(s)
To To	Mec	29b. Signature and title of certifier	and manner stated.			29c. Lice	nse number			29d.	Date signed (	Month, Day, Year)
		11 . "	.11.	_	0	0.0	C.M.E.		OCME	July	y 25, 2009	
		30. Name and address of person who	Kung 3	12. M	2	),						
d		Theodore M. King, Jr., MD		- die al Evamin	er	111 Penn S	Street, Bal	ltimore	e, MD 212	01		
$\psi$	nto	31. Date filed (Month, Day, Year)	32 Registra	r's Signature	600	Kal						
Regis	ate Irar	1111 3 1 200	19 Gener	P. 19	A. S. C. C.							

# 3altimore, Maryland 21215-0036

/Medical Examiner

Box 68760% P.0. Division of Vital Records,

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month **Physician** July 27,2009 5:10 Mary Louise Hall /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1413 Barrett Road Baltimore

I If Under 24 Hrs. Baltimore 8. Date of Birth (Month, Day, Year) 03/30/1937 If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days Hours 1 □ M 2 □ XF 215-34-7626 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10h County 28a-f show other traumatic event, the Medical Examiner must be notified at MD 1 □Yes 2 No Baltimore Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 23a 1413 Barrett Road 21207 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or items Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: þ Specify.White 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Scan Coordinator Grocery/Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Russell Mathias Lucy Trammell ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Warren E. Hall (Spouse) 1413 Barrett Road, Baltimore, Maryland 21207 Department of Heali Important: If item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn Gardens 07/31/2009 Marriottsville, MD 4 Depation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** METASTATIC MONTH disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Yes 2 1 ☐Yes 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28h. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and myanner stated. 29b. Signature and title of certified ause of death (Item 23a) (Type, Print) 0 Registrar's Signaty State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 27 rules MORRIS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ANDAILS were XGNTHINES If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Year) Days Hours 1**X** M 2□ F Months 12/15/1916 143-12-7290 92 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "---" any Injury or other than "---" 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Director BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code 725 MT. WILSON LANE, #629 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married WHITE 1 □Yes 2 No Specify: ⋧ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry DISTRIBUTOR Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED WISE POTATO CHIPS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **ABRAHAM** KATZ GITTEL WHITTMAN ဨ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9900 MIDDLE MILL DR., OWINGS MILLS, MD 21117 DAVID KATZ / SON 20b. Place of Disposition (Name of cemetery, cremator) A Poster Pace Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State □ 07/30/2009 KING DAVID MEMORIAL FALLS CHURCH, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Lic 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to ( r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of; and burial-tran Due to (or as a consequence of): the attending physician hed for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) detached 9 Unknown sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □→10 24a. Was an autopsy performe CORENANI 2 110 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this funeral 27. Mann of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Division of Vital Records, P.O. Box 68760, Hospital or Attending death. 24 hours after death Funeral Director:

Location (Street and Number or Rural Route Number, City or Town, State)

1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifie

29a. Certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

URIANDO 31. Date filed (Month, Day, Year 6

State Registrar

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department	artment of Health and M rtificate of Death		ene . N 2 0 0 9	24619
Physic		Decedent's Name (First, Middle, Last)	SSBERG	2. Date of Death Month JULY 28,	Day Year	3. Time of Death
/Medi Exami		4a. Facility Name (If not institution, give street and number) GOLDEN LIVING CENTER	4b. City, Town, or Location of Death WESTMINSTER		4c. County of Deat	
Funeral Director		5. Social Security Number 099-16-3289 6. Sex $_{1}X \ M \ 2 \ F$ 7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year   If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, ) 05 - 23 - 192	/ear) 9. Birt	hplace (State or Foreign untry) NY
e Maryland Sa-f show	Director	Usual Residence of Decedent	3	100	g. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 No
with th	1 Dire	10e. Street and Number	10f. Zip Code 21048	, , ,	USA	
I e, INIAL y IAILU A IAINO OOO  1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I'm Medical Exprises overtous by notified at	by Funeral	4 Thursday of Married 1 Tyes 20100	Was Decedent of Hispanic Origin? (Si If Yes, specify Cuban, Mexican, Puerto 1 □Yes 2 <b>∏</b> No Specify:	pecify Yes or No- Di Rican, etc.)	14. Race - Ame Black, Whit Specify: WH	
vithin 72 hourshe.	Completed	15. Decedent's Education (Specify only highest grade completed) (Give life.	dent's Usual Occupation kind of work done during most of work DO NOT use retired) ECTRICAL ENGINEER		JOHNS H	
violities of the vith Mental Hygiene arked other than attic event, trees	Be Co	17. Father's Name (First, Middle, Last)		ne (First, Middle, Mi		
alyland A	10 B	MAX KONIGSBER	G ROSE ing Address (Street and Number or Ru	iral Route Number		PER Zip Code)
es 1 and 2 sh of Health and fitem 27 is m		HELEN KONIGSBERG/WIFE 470  20a. Method of Disposition 20b. Place of Disposition	9 CREEKSIDE CR. #	202, OWIN		MD 21117
t. Pag tment tment tant: I	- Source	1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	E HEBREW 07-3 2. Name and Address of Facility SO 8900 REISTERSTOWN	L LEVINSC	ISTERSTOW ON & BROS.	, INC.
	OI .	23a. Part 1. Enter the disease, or complications I lat caused the death. Do not er shock, or heart failure. List only one cause in each line.  Immediate Cause (Final				Approximate Interval Between Onset and Death
Cate be executed  Cate be executed  Cate be executed  Cate building and  Cate building an	ıl	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Estruelme Pa	longran	y Disease	Zyn
death certifi e attending i	hvsician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 4 □ Pregnant at time of death 5 9 □ Unknown	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of d Month	elivery Day Year
ords, F.O. requires that the seen signed by the hould be detached.	2	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		_	to the cause of death?  Probably 4  Unknown
The lar ate has	Completed				prior t death 2 No 1 Ye	autopsy findings available o completion of cause of ? es 2 \( \square\) No
	å	25. Was case referred to medical examiner?		eath (Check only on Home 5  Reside	e) ence 6 ☐Other (S	pecify)
ing Affer uner	Cortification: To	27. Man   of Death 28a. Date of Injury (Month, Day, Year) 28b. Time Injury (Month, Day, Year) 22b. Time Injury 22 Accident investigation			ow injury occurred	
Division  al or Attendi s after death. ii Director: A ed in by the fu	Sprtific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, se building, etc. (Specify)		City or Town	n, State)	Rural Route Number,
DIVI To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Modioal		eath occurred at the time, date and pla investigation, in my opinion, death oc	curred at the time, c		
To the within 2 To the comple	M	29b. Signature and title of certifier	29c. License number	2	29d. Date signed (Mo	onth, Day, Year)
		30. Name and address of person who completed gause of death (Item 23a) (Typ	e, Print) / 443		1100/2	7
		John W. Middleton 3337 Viet	my Street n	Jancher	ta, MD	21102
	State	THE ALL COUNTY CARRY	Payer		,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Abraham /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner antai Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday)
Yrs. Security Number If Under 1 Sex 1 M 2 ☐ F **Funeral** Min Days Hours 518-37-886 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 12. Was Decedent Ever in U.S. Armed Forces? 120 Yes 2 □ No 17 Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married Married 1 ☐ Yes 2 No Specify 2 Nhite 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, 17. Father's Name (First, Middle, Last) Schmit ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DONAID 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 Removal from State 21. Signatu of Funeral Service Licens 22. Name and Address of u urra Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ebstain Barr Virus **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed for use as the burial-transit and Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sate has been signed page 2 should be del Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy performed certificate 2□No funeral director. 25. Was case referred to medical examiner? 26. Place of Death Check onl one No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760, Division or Vital Records, the Hospital or Attending Physician; thours after death.

uneral Director: A
ely filled in by the fu within 24 hours at To the Funeral C

Baltimore, Maryland 21215-0036

State Registrar

29a. Certifier (Check only one)

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) JUL 3 1 2009 32. Registrar's Signal

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c, License number

29d. Date signed (Month, Day, Year)

July, 27, 2009 al Naval Medical Centler

Physi /Med Exan

Funera Directo

Physicia

		For State Registrar	i iviai yiaii		•	ificate d			_	Reg. N	0.0	09	24	621
ciar		1. Decedent's Name (First, Middle, Last)	, ,	-					2. Date of De Month	D		<b>/e</b> ar	3. Time o	
dica			harles	Laı	kin				Ju1y_	27			9:03	P M
nine	r	4a. Facility Name (If not institution, give street and nur	mber)			4b. City, Tow					c. County of			
		Holy Cross Hospital  5. Social Security Number   6. Sex	7. Age (In yrs. I	ast birtt	ndav)	Si.		pring der 24 Hrs.	8. Date of Bir		ontgor	9. Birtho	place (State	or Foreian
al or		186-48-7931 ¹¼™ 2□ F	51		rs.		ys Hou		8. Date of Bir (Month, Da April 2	y, Year	958 I	Coui	ntry) sy1var	9
	}	Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town	or Loca	ation						1	Od. Inside C	ity Limits
3	5	Maryland Montgomery		Si1	vor	Sprin	C.						1 ☐ Yes	2 <b>₭</b> No
3	2	10e. Street and Number		011	·VCI	10f. Zip Co				10g. C	itizen of Wh	at Cour	ntry?	
2	ב פ	9228 Manchester Road					20901			Un	ited S	Stat	es	
1	i je	11. Marital Status 12. Was Dece Armed Fo	edent Ever in U.S	3.	13. W	as Decedent Yes, specify (	of Hispanic	Origin? (Sp	pecify Yes or No Rican, etc.)	-		- Americ	can Indian,	
11 14	completed by Funeral Director	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes If Yes, Gi Year or D	2.ሺ No ve			⊒Yes 2 <b>X</b>					Specify:		ite	
3	ě	15. Decedent's Education (Specify only highest grade completed)		16a.	Decede (Give ki	nt's Usual O ind of work do O NOT use re	cupation one during r	nost of work	king		Kind of Busi al Est			
1 8	<u>a</u>	Elementary/Secondary (0-12) College (1	-4or 5+)			Develo					ar Es velopi			
		17. Father's Name (First, Middle, Last)		ي ا	and	релет	_	other's Nam	e (First, Middle,				•	
á		Robert Larkin						lores			tanov			
Ę	=	19a. Informant's Name/Relationship (Type. Print)		19b.	Mailing	Address (St			ral Route Numb				Code)	
		Rachel D. Montenegro / W	ife	922	28 M	lanches	ter R	Road,	Silver	Spr	ing, N	Mary	land :	20901
	Ì	20a. Method of Disposition	20b. P			tion (Name o		1	Date		Location - C			
aŭ.		1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeya Sprvice Licensee	State I		ry Cı	ematori	um, Inc	200	-				arylar	
once		Mystellesarput	M01	305	Rob 755	ert A. 1 7 Wisco	umphrensin Av	y Funer venue,	ral Home/ Bethesda,	Beth Mar	nesda-Cl yland 2	nevy 20814	Chase, -3501	Inc.
		23a. Print1. If ter the disease, or complications that of stock, or heart failure. List only one cause on e	aused the death ach line.	. Do n	ot enter	the mode of	dying, such	n as cardiac	or respiratory a	rrest,			Approxima Interval Be Onset and	tween
n	ĺ	Immediate Cause (Final disease or condition Athe	roscler	otio	c Ca	rdiova	scula	ar Dis	ease			ĺ	Oriset and	Death
al I		resulting in death)  Due to	(or as a consequ	ience o	f):									
	ŭ	Sequentially list conditions, if any leading to immediate Due to	(or as a consequ	ience o	f):						_			
Evaminor		Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,		,									
2	EXa	resulting in death) Last Due to	(or as a consequ	ience o	f):									
2	Sa	d												
Mod	Nec.	IF FEMALE:												
,40	2	23b. Was decedent pregnant 1 Live	tcome of pregna birth 2  Fetal	death		Ectopic pregi					23d. Date Mon		ery Day	Year
lecipos//acioismad	yor	1 ☐ Yes 2 ☐ No 4 ☐ Preg 9 ☐ Unknown 9 ☐ Unkn	nant at time of d nown	eath	5 🗀	Other (specif	/)						,	
		Part II. Other significant conditions contributing to de	eath but not resu	ılting in	the unc	lerlying caus	given in Pa	art I.	23e. Did t	obacco	use contril	oute to t	he cause of	death?
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Completed by									24a. Was	an	24b. W	ere auto	opsy findings	available
}									auto	rmed? 2 X 1	pr de	ior to co eath?	opsy findings ompletion of 2  No	cause of
2		25. Was case referred to medical					26, P	lace of Deat	1 ☐ Yes th (Check only o		40 1 11	163	2 🗀 140	
		examiner? 1 ☐ Yes 2 🖾 No Hospital:	Inpatient 2 ី🛚	ER/Out	patient	3 □ DOA	Other: 4 [	Nursing H	ome 5 ☐ Resi	dence	6 □Othe	r <i>(Speci</i>	fy)	
ġ	5	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date (Mon	of Injury th, Day, Year)	28b. Ti	ime of jury		Injury at Work?		28d. Describe	how inj	ury occurre	d		
400	2	2 Accident investigation				М	1 ☐ Yes 2	2  No	201.1				15	
, ortif		4 Homicide determined 28e. Place buildi	of Injury - At hoing, etc. (Specify	me, tari	m, stree	ет, тастогу, оп	ce		28f. Location ( City or To	Street i vn, Sta	and Numbe ite)	r or Hun	ai Houte Nui	nber,
Modical Cartification. To	calcal	29a. Certifier (Check only one)  1 Certifying Physician: To the 2 Medical Examiner: On the base and man	e best of my kno easis of examina ner stated.	wledge, tion and	, death d/or inve	occurred at t estigation, in	ne time, dat my opinion,	te and place death occu	e, and due to the rred at the time,	cause date a	(s) and mar ind place, ar	nner as nd due t	stated. to the cause	s)
NA.	Ξ	29b. Signature and title of certifier	1.5				ense numb			29d. E	Date signed			
		Potte	~) 			D D	2434	8			0 ~	1. 2	-7.2	200
		30. Name and address of person who completed cause Steven Grufferman, M.D.					head	Silva	r Sprin	o . 1	Marv1.	and	20910	
state			1 0			- Luit L	.oau,	DIIVE	r obrin	5, 1	. тату т	u		
strar	-	JUL 31 2009 General	registrars Signa	ark										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2009 **Physician**  $A^{\mathsf{M}}$ 29, 9:15 July Elenore Phyllis Lambidakis /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Manor Care Potomac Potomac If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Country) Ew York 1 □ M 2 X F 14, 1931 New 116-24-3898 77 December Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.
nt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ural", or items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 □ No Directo Takoma Park Maryland| Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20912 United States 7213 Cedar Avenue Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No White Saltimore, Maryland 21215-0036 Specify: þ 3 X Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) n and Mental Hygiene. College (1-4or 5+) Writer Self Employed permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygier Important: If item 27 is marked other th any Injury or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Perry Walter Nystrom Bertha White ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11005 Piney Meetinghouse Road, Potomac, Maryland 20854 Stephanie E. Lambidakis/Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition July 30, 1 ☐ Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Bethesda, Maryland Montgomery Crematorium Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 21. Signature of Funeral Service Licenses 6 \_M01173 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Lung Cancer /Medical Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? es 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident hours after death uneral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a the Hospital 1 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 29, 2009 00057458 cause of death (Item 23a) (Type, Print) 30. Name and address of person who compile Pinky S. Singh, M.D. 6502 Kenilworth Avenue, Suite 100, Riverdale, Maryland 20737 31. Date filed (Month, Day, Year) JUL 31 2009 Registrar

			For State Registrar	State of Ma	ıryland / I		nent of H cate of L		Mental Hy	giene Reg. No.	0000	24623
			1. Decedent's Name (First, Middle, La	st)					2. Date of De	ath	Year	3. Time of Death
	Physici /Medio		Paul B Leb	0					07	25	7 2009	1700 M
	Examin		4a. Facility Name (If not institution, giv	e street and number)		4b.		Location of Dea	th	4c.	County of Deat	h
			5. Social Security Number 6. S	7 100	(In yrs, last bi	irthday) If U	Ba His	MOS — If Under 24 Hrs	8. Date of Bir	th	9 Birt	hplace (State or Foreign
	Funeral Director		,	<b>⊠</b> M 2□ F	54		nths Days	Hours Min		195.	Co	untry) PA
	ס		Usual Residence of Decedent						TIVOVASA		1	
	arylan show	<u>_</u>	10a. State 10b. County PA Cumber1	and	10c. City, Tow		lisle					10d. Inside City Limits 1 □Yes 2【No
	he Ma	ectc	10e. Street and Number				f. Zip Code			10a Citi	zen of What Co	
	23a or	Funeral Director	160 Faith Cir	cle				7013		rog. On	USA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		11. Marital Status  1   Never Married 2   Married 3   Widowed 4   Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 ☑ N If Yes, Give Year or Dates:		If Yes	Decedent of Hi , specify Cuba es 21X No	spanic Origin? ( n, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	)-	14. Race - Ame Black, White Specify:	
5-0	72 hc 'natul	Completed by	15. Decedent's Education (Specify only highest graduation)	ducation ade completed)	16a	(Give kind	Usual Occupa	luring most of wo	rking	16b. Ki	nd of Business/	Industry
121	filed within Hygiene. other than "	m d	Elementary/Secondary (0-12)	College (1-4or 5-	+)		ot use retired ne Oper	· .		st	eel Mil	1
	filed Hygid		17. Father's Name (First, Middle, Last	<u>'</u>			10 01	18. Mother's Na	me (First, Middle	, Maiden		
lan	iould be filed within a Mental Hygiene. Tarked other than 'natic event, Ire IM.	To Be	George Oren Le	bo				Gay	le Esth	er		
Mai	alth and Mer 27 is marke r traumatic		19a. Informant's Name/Relationship ( John Lebo / Bort						t, White			
Baltimore,	Pages 1 and 2 ment of Health s ant: If item 27 is ury or other tra		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ 4 □ Donation 5 □ Other (Specia			of Disposition ery, cremator L Crem	(Name of y or other plac atory	e) 7/3	Date 0/2009		cation - City or anover,	
Balti	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licer	Isee Porota M	arshal	⁺∣ Ma	rylan	d Crema	ation S Baltimo	erv	ices	203
	-		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do	not enter the	mode of dyin	g, such as cardia	ac or respiratory a	arrest,	11112 21	Approximate Interval Between
and a	Physician		Immediate Cause (Final disease or condition		school	c 5/0	oke					Onset and Death
A	/Medical		resulting in death)	Due to (or as	a conseque me	of):						
	Examiner	_	Sequentially list conditions,		object		2 is a					
	ted nsit	nine	if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	a consequence	· UI).						
	icate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as	a consequence	of):						
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9	rtificat ng phy as th			110000								
O. Box	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal deat		opic pregnancy er (specify)	<i>y</i>			23d. Date of de Month	livery Day Year
Ф.	that the de ned by the detached		Part II. Other significant conditions	contributing to death bu	it not resulting	in the underly	ving cause give	en in Part I.	23e. Did	tobacco ι	use contribute to	the cause of death?
Vital Records,	quires in sign uld be	d by							. 10	Yes 2	<b>⊈</b> No 3□P	robably 4 🗆 Unknown
000	aw require s been si 2 should b	Completed							24a. Was		24b. Were at	topsy findings available
æ	: The law cate has page 2 s	E O							auto perf	ormed? 2 No	death?	completion of cause of 2 □ No
Ital	nysician: The nis certificate I director, page	Be C	25. Was case referred to medical examiner?					26. Place of De	eath (Check only			
of V	hysic this ce al dire	2	1 Yes 2 No		nt 2 ER/O		□ DOA Othe	er: 4 🗌 Nursing	Home 5 ☐ Res	idence	6 □Other (Spe	ecify)
n c	ng F offer oner	ion:	27. Manmer of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Day	ry 28b. <i>(, Year)</i>	Time of Injury	28c. Injur	₹?	28d. Describe	how injur	y occurred	
isio	Attendi death. ctor: A y the fu	icati	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b		rv At home f	arm street f		Yes 2□No	28f Location	(Straat ar	d Number or P	ural Route Number,
Division	after after Direction by	Certification:	4 Homicide determined	e 28e. Place of Inju building, etc	Specify)	arrii, street, i	actory, office		City or To	wn, State	)	urai Fronte Number,
_	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 ☐ Certifying P	nysician: To the best of miner: On the basis of and manner sta	examination a	ge, death occ and/or investi	urred at the tirgation, in my o	ne, date and pla pinion, death oc	ce, and due to the curred at the time	e cause(s , date and	) and manner a d place, and due	s stated. e to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier				29c. Licens	e number		29d. Da	te signed (Mon	th, Day, Year)
			1	110			D00.	66999	_	CT	7/25/	09
			30. Name and address of person who	completed cause of d	eath (Item 23a)	(Type, Print						
			AKINTId	2009 Acles	loyin	22	Sarth	Greene	st Baltin	112	OSIS am	1
	Sta		31. Date filed (Month, Day, Year)  JUL 31	32. Redistra	ar's Signature	1. Ana	Mar					
	Registr	ar	JULJI	C003 /		. //						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Geoffrey P Lawrence State of Maryland / Department of Health and Mental Hygiene 2009 24624 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day July 27, 2009 0203 hrs **Medical Examiner** Geoffrey Ρ. Lawrence 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Davs Hours Min. August 25,1945 Months Director 059-38-4879 1 X 2 F 63 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County Silver Spring 1 Yes 2 XNo MD Montgomery 23a or 28a-f show notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20901 8518 Bradford Rd. Funeral 13. Was Decedent of Hispanic Origin? ( Specify Yes or No 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. þe If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Armed Forces? must 1XX yes White If Yes, Give YeaVietnam Yes 2X No specify: Specify: Widowed 4 Divorced Era Examiner 3 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than 'atic event, the Medical 21215-0036 4 Telemarketer Magazine Sales 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Jean Ross Leslie Lawrence Harry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $356\ Guy\ Park\ Ave.,\ Amsterdam,\ NY 12010$ 19a. Informant's Name/Relationship (Type, Print.) 2 Joseph R. Lawrence / Brother item 27 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date Baltimore, tant: If it or other t crematory or other place) Burial 2 X Cremation 3 Removal from State 7/31/2009 Beltsville, MD Chesapeake Crematory Donation 5 Other Specify 22. Name and Address of Facility Rapp Funeral and Cremation Services Fun ral Service Licensee M00932 933 Gist Ave., 20910 Silver Spring, MD WXXXW 23a, Part I. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Univerlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical 23a,27,PII per ME g894 8/12/09 TT g physician a the burial -X UNPENDED To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death signed by the attending be detached for use as past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 V Unknown Coaine use Completed Records, has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? director, page ✓ Yes certificate ✔ Yes 2 26.Place of Death (Check only one) Division of Vital 25. Was case referred to medical Be Other<sub>4</sub> examiner? Hospital: 1 Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 Other: this 1 Yes No 28a. Date of Injury (Month, Day,Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural neral Director: Yes 2 Pending Accident Investigation 24 hours after d 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide To the Fune completely f 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number July 27, 2009 O.C.M.E. orbers 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Donna M. Vincenti, MD Assistant Medical Examiner 31. Date filed (Month, 2. Registrar's Signature State

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** July 23,2009 7:18P Dolores Eve McManus /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford 3004 Scenic View Drive Forest Hill If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 🗓 F Director Maryland March 18,1932 215-34-0271 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show r than "natural", or items 23a or 28a-f shov the Medical Expressional be nutified at 1 ☐ Yes 2√☐ No Md. Harford Forest Hill Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 3004 Scenic View Drive 21050 US 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 📆 No Specify: Specify. White 3 ☐ Widowed 4 😾 Divorced 16b, Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Practioner Medical 7 is marked other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Christopher Geotz Mary Schollian 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 3004 Scenic View Drive Forest Hill, Md. 21050 DTR. Kerry McManus-Marconi item 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 permit. Pages Department of Important: If it any Injury or once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-28-2009 Baltimore City, Md. Bayview 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home 610 W. MacPhail Rd. BelAir, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 200 COSON GG1 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician: The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? been signed by the atter should be detached for u 3 Ectopic pregnancy 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 □Yes 2 □ No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 20 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \( \Bigcap \) Nursing Home Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 5 Residence 6 □ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred or Attending 1 Natural 5 Pending s after death.

I Director: Al investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral I

completely filled To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type,

Registrar

State

9106

Registrar's Signature

La mis.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 07-27-2009 Year **Physician** 0001 A Daniel S. Muirhead /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10-15-1949 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months Hours Days 1**X** M 2□ F 214547611 59 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Evandant rough by notified at 1 ☐ Yes 2√2 No Director MD Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 1602 Prindle Dr 21015 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2X No Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: if item 27 is marked other than any Injury or other traumatic event, it is in a gone. Elementary/Secondary (0-12) Estimator Steel Fabrication 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard J. Muirhead Minnie A. Cunningham 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Muirhead (Wife) 1602 Prindle Dr Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07-28-2009 | Baltimore, MD Bayview Crematory 21. Signatur of Funeral Service Licens 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Road Bel Air, MD 21014 Approximate Interval Between Onset and Death 23a. Part 1. Enter (the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** eukemia unknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 🗆 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Cardiac arrest 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? acidosis 24a Was an autopsy respiratory failure 2 **23** No 1 ☐ Yes 2 ☐ No 1 □Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 or Attending 1 Natural 5 ☐ Pending investigation 1 □Yes 2 □No 2 Accident s after death filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide e Funeral I Hospital 29a. Certifier 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) completely and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0065421 July, 27, 2009 MD

State Registrar 31. Date filed (Month, Day, Year)

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Barks

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christa R. Fister, 500 Upper Chesapeake Drive, Bel Air, MD 21015

32 Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State of Waryland / Depart	tificate of Death		g. No. 2009 24627
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  John Norbert McDonough		2. Date of Death Month	Day Year 3. Time of Death
1	Examin		4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center	4b. City, Town, or Location of Death	on	4c. County of Death Baltimore
Ī	Funeral Director		5. Social Security Number 213-12-6652   1 M 2 F   7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year   If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Pay, Aug 16,	9. Birthplace (State or Foreign May 91 and
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Local	ation		10d. Inside City Limits
	Maryl a-f sho	tor	MD Baltimore Luth	erville		1 □Yes 2 <b>Y</b> No
	th with the 23a or 28 list be not	Funeral Director	10e. Street and Number 220 Meadowvale Road	10f. Zip Code 21093	10	g. Citizen of What Country? U.S.A.
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, tre Maries Examinational to notified at once.	þ	1 □ Never Married 2 □ X Married 1 □ Yes 2 √ □ No	as Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto ☐Yes 2 <b>X</b> No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
21215-0036	within 72 horiene.  than "natu	Completed	(Specify only highest grade completed) (Give k	ent's Usual Occupation ind of work done during most of work O NOT use retired) 'Chasing	ing 1	6b. Kind of Business/Industry  Martin Marietta
nd 2	e filed al Hyg I other vent, I	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, M	aiden Surname)
, Va	ould b d Ment narked natic e	卢	Patrick J. McDonough, Sr.		Marie	Streb
, Maryland	and 2 sh ealth and n 27 is n her traun	7.0	Clara A. McDonough-wife 220	Meadowvale Rd., l	_uthervil	le, MD 21093
Baltimore,	. Pages 1 tment of H tant: If iter jury or oth		20a. Method of Disposition  1 □XBurial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)  20b. Place of Disposition  Cemetery, cremit  Most Holy	Redeemer 8/1/	/09	Oc. Location - City or Town, State  Baltimore, MD
Bal	permit Depar Impor any in	, 1	21. Signature of Funeral Service Licensee William G. Dau 1	Name and Address of Facility Ruc .050 York Rd., Tow	ck Towsor wson, MD	Funeral Home, Inc. 21204
-	Physician /Medical	8	23a. Part 1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a. INTRACRANIAL HE resulting in death)	r the mode of dying, such as cardiac		st, Approximate Interval Between Onset and Death
	Examiner		Due to (or as a consequence of):			
	ted nsit	Examiner	Sequentially list conditions, if any k-admin to the consequence of the cause. Enter Underlying Cause (Disease or injury that initiated events			
68760,	rificate be executed by physician and as the burial-transit		that initiated events resulting in death) Last   Due to (or as a consequence of):			
		fedic	d			
P.O. Box	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use	Physician/Medical		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ς, σ,	s that t gned by e detac	by Ph	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.	23e. Did tob	acco use contribute to the cause of death?
ord	w require s been siç should b	ted t	METASTATIC LIVER CANCER		1 □ Ye	s 2 No 3 Probably 4 Unknown
al Rec	ding Physician: The law in the law in the faw in this certificate has but funeral director, page 2 st	Completed			24a. Was an autopsy perform 1 □Yes 2	prior to completion of cause of death?
ΖΪ	rsician s certif lirector	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No	Other:	th (Check only one	nce 6 Other (Specify)
n of	ng Phy fter this neral o	on: To	27. Manner of Death  11♥ Natural 5 □ Pending (Month, Day, Year)  11♥ Natural 5 □ Pending (Month, Day, Year)	28c. Injury at Work?	28d. Describe ho	
Division of Vital Records,	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, streed building, etc. (Specify)	M 1 □Yes 2 □No et, factory, office	28f. Location (Str City or Town	eet and Number or Rural Route Number, State)
	Hospital 24 hours Funeral etely filled	Medical Co	29a. Certifier (Check only one)  One)  Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or inv and manner stated.			
	To the within 2 To the comple	Med	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29	od. Date signed (Month, Day, Year)
	121		30. Name and address of person who completed cause of death (Item 23a) (Type, P	DE4Ø34		1/28/07
_	121		TIMOTHY LOW. M.D. 7601 OSLER DI		MARYLAN	D 21204
	Sta Registr		31. Date filed (Month, Day, Year)  32. Figistras's Signature  33. Figistras's Signature	ald		

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			For State Registrar	State	of Maryla	ind / Depa	artmen			and M	lental Hy	giene Reg. No.	109	24628
			Decedent's Name (First, Middle	e, Last)							2. Date of De		Year	3. Time of Death
	Physici /Medic		Catherine N	lurphy							July	29,	2009	5:15 P M
5	Examin		4a. Facility Name (If not institution	n, give street and n	umber)				Location of	of Death		4c. Cou	nty of Death	1
			Keswick  5. Social Security Number	6. Sex	7 Ago //p.us	s. last birthday)	Balt		e If Under:	24 Hrs.	8. Date of Bi	-th	o Rieth	uplace (State or Foreign
	Funeral Director		217-09-6291	1 ☐ M 2 1 X F	89	s. rasi birtinday) Yrs.	Months	Days	Hours	Min.	Nov. 8	ay, Year)	Cou	Maryland
	ס		Usual Residence of Decedent								NOV. C	1919		
	arylar show	_	10a. State 10b. County			City, Town or Lo	cation							10d. Inside City Limits
	he M	Director	MD Balti	more	Ph	oenix	10f. Zip	Codo				10g. Citizen	of What Cou	1 Yes 2 No
	with Se or			n Way				131				USA	or what cou	,
	death	Funerai	3805 Duddingto	12. Was De	cedent Ever in	U.S. 13.			spanic Ori	gin? (Sp	ecify Yes or No Rican, etc.)		lace - Amer	
9	after or its		1 Never Married 2 Mar		2 17 No	1	ii res, spec 1 □ Yes		n, mexican Specify:	i, Puerto	rican, etc.)		Black, White	vhite
g	within 72 hours after death with the Maryland ene. Than "natural", or Items 23a or 28a-f show he Macinal Exeminar mast be notified at	Completed by	3 Widowed 4 □ Divorced	Year or	Dates:									
21215-0036	in 72	olete	(Specify only highe			16a. Dece (Give life.	dent's Usua kind of wo DO NOT us	n Occupa rk done d se retired	ation during mosi ")	t of work	ing	16b, Kind o	f Business/li	naustry
212	with giene.	mo	Elementary/Secondary (0-12)	College	(1-4or 5+)	Cleri						Black	& Dec	cker Inc.
ਰੂ	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is merked other than "natural", or items 23s or 28s-f show aumatic event, the Macical Exertiret mast be notified at	Be C	17. Father's Name (First, Middle,	Last)					18. Mothe	er's Name	e (First, Middle	, Maiden Sun	rame)	
yla	ould the Ment	<sup>2</sup>	Robert Myers								uerling			
Maryland	12 sh h and 7 is m traum		19a. Informant's Name/Relations Denise C. Moss		ab+a.a		•				al Route Numb			ip Code)
آو آ	permit. Pages 1 and 2 should be Department of Heatth and Menta Important: If Item 27 is marked eny Injury or other traumatic ev <u>page</u> .		20a. Method of Disposition	, / ua	ughter 20b	. Place of Dispo	sition (Nar	ne of	1		Phoenix Date		on - City or 1	Fown, State
Baltimore,	Pages ent of nt: If I		1 Burial 2 Cremation 4 Donation 5 Dother (5	3 □Removal from pecify)		cemetery, cres		·		8/6,	/09	Ralti	more.	MD
att	permit. Departm Importa eny Inju		21. Signature of Fin-al Service	4	/	1 1	2. Name an				03		_	k Road
<u> </u>	8258		1 Ou	J. Lee	4						l Home		wson,	MD 21204
П			23a. Part1. Enter the disease, o shock, or heart failure. List	complications that only one cause	caused the de each line.	eath. Do not ent	_			cardiac	or respiratory a	irrest,		Approximate Interval Between Onset and Death
)	Physician		Immediate Cause (Final disease or condition resulting in death)	a	9 AS	tri c	(m	100	R					Jean
	/Medical Examiner		rooming in accumy	Due to	o (of as a cons	equence of):								0
		er	Sequentially list conditions, if any, leading to immediate	b. Due t	o (or de a cone	aquence of):								
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C										
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×	that the death certifica ed by the attending ph detached for use as th	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, c	utcome of preg	gnancy						23d.	Date of deli	verv
m	death e atter d for u	iciar	in the past 12 months?	4□Pre	birth 2□Fe gnant at time o		⊒Ectopic pr ⊒ Other (sp						Month	Day Year
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<u> </u>	iclan: Th certificete rector, pag	မ ငိ	25. Was case referred to medica						OC Diese	of Doot	1 ☐ Yes	2 🗆 No		2 No
>	ysicia is cert direct	ToB	examiner? 1 Yes 2 No	Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3 DC	Oth		,	me 5□Res		Other (Spec	eify)
Ö	ng Phys fter this ineral di	L:uo	27. Manner of Death 1 ☑Natural 5 ☐ Pendii	/8.40	e of Injury onth, Day Year)	28b. Time o	f 2	8c. Injury			28d. Describe			
Division of	tendii leath. tor: A the fu	cati		gation			М		Yes 2 🗆	-		(0)		
$\overline{\underline{S}}$	or At after of Direct in by	Certification:	4 Homicide determ	nined 286. Pla	ce of Injury - At Iding, etc. (Spe	t home, farm, st cify)	reet, factory	, office				(Street and Ni own, State)	imber or Hu	ral Route Number,
_	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 1 Certifyi	ng Physician: To t	he best of my k	nowledge, deat	h occurred	at the tim	ne, date an	id place,	and due to the	cause(s) and	manner as	stated.
	he Ho n 24 h he Fu pletely	Medicai	(Check only 2 Medical one)	Examiner: On the	basis of exami inner stated.	nation and/or in	vestigation	, in my op	pinion, dea	ith occur	red at the time	, date and pla	ce, and due	to the cause(s)
	Within Com	Σ	29b. Signature and title of certifie		0	1110	290	. License	number		_	29d. Date sig	gned (Month	Day, Year)
)	6.1		My Must	my 100	1			12	200			July	10,0	00/
	OV		30. Name and address of person	who completed ca		tem 23a) (Type,	Print)	ha	rle	57	. Ba	Cho.	md	21204
·y-	Sta	te	31. Date filed (Month, Day, Year,	32	Adyistrar's Sig						. /	•		
	Registr		JUL 31	2009 1	neva	1. 60	ales							

DHMH 17 Rev 1/2001

Katarina Ann Morism

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day July 27, 2009 Year Medical Examiner 0511 hrs Katarina Ann Morrison 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death White Marsh Boulevard and Honeygo Boulev **Baltimore County** Perry Hall 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) **Funeral** Country) Months Days Hours Min Director 170-72-6651 19 M 2 XF 6/2/90 Usual Residence of Decedent ī 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No PA Delaware Media permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-5 sho Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country 802 N. Monroe Street USA 19063 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married 2 X No Yes Specify: White 3 Widowed Divorced Yes Give Year Yes 2 X No specify. \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Not Self Supporting Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12 2 Dependent 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) æ Robert Tomlinson Tracy Morrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Morrison Ν. Monroe St. Media, PA 19063 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery. Date 20c. Location - City or Town, State Important: If its injury or other t crematory or other place) X Burial 2 Cremation SS Marple , PA Peter And Paul 8/4/09 Other Specify: Donation 5/1 22. Name and Address of Facility eral Service Licens 15 E. Fourth St. Rigby Harting and Hagan Media PA,19063 Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and failure. List only one cause on each line /Medical a. Multiple Injuries Death Immediate Cause (Final disease ~xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical attending physician or use as the burial UNPENDED AMENDED Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 ✓ Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. <u>چ</u> Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? certificate h ector, page Yes 2 Yes No ~ To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Other; Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene 1 V Yes No 28a. Date of Injury Jul 27, 2009 28b. Time of Injury 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Work? Certification: Occupant in motor vehicle collision 0000 hrs 1 Natural Yes 2 🗸 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) White Marsh Boulevard and Honeygo Boulev, Perry Hall (Specify) Major Road / Highway Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

12 State Registra

Assistant Medical Examiner 32. Fegistrar's Signature

111 Penn Street, Baltimore, MD 21201

O.C.M.E

July 28, 2009

Carol Allan, MD 31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** PM Jean McClain Doris /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1V15TA PLATE -HARL MEDICAL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** Year) 1 □ M 2 🖫 F Months Days Hours Min. 75 Yrs 186-26-7875 Director 01 <u>34</u> PA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Wedical Examination at Director Y☐Yes 2☐No PA Allegheny Pittsburgh 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15208 7055 Monticello Street U.S.A. Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes No
If Yes, Give
Year or Dates: 1 Never Married 2 Married バレートサイト しつべい Baltimore, Maryland 21215-0036 1 □Yes 2 📉 No Specify: ģ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygienn Important: If Item 27 is marked other the amy injury or other traumatic event, the once. 12th grade Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Williams 2 Carrie Parker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5608 Daniel Circle, Waldorf, Md 20601 Doris Cabiness-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Homewood Cemetery 8/4/09 Pittsburgh, PA ture of Funeral Service Licensee 22. Name and Address of Facility
Coston Funeral Homes, Inc. Lincoln Ave, Pittsburgh, PA 15206 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ilia COC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live birth 2 Fetal death in the past 12 months? Month Dav Year 4 Pregnant at time of death detached 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 HO 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1-Natural 5 Pending investigation 1 ☐Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: # 2 Accident filled in by the Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only the

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

hausen

Baia

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6620

Crain

32. Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

La Plata, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** July 24, 2009 Joseph 8:50 P. M Harry Meyers /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 559 Chestnut Hill Road HArford Forest Hill 8. Date of Birth (Month, Day, Ye July 30, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral , 1926 Maryland Months Days Hours Min. 82 **Director** 212-20-4590 Usual Residence of Decedent 10a State 10c. City. Town or Location 10b County 10d Inside City Limits r than "natural", or items 23a or 28a-f shoothe Wedical Exercitors is ust be retilled at Director 1 □Yes 21 No HArford Maryland Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 212 Crocker Drive Apt. E United States Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1⊠Yes 2□No
If Yes, Give
Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1943-1 ☐ Never Married 2 ☐ Married 1946 1 ☐ Yes 2 No ģ Specify: Specify:White 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed w h and Mental Hygiei 7 is marked other th 12 Computer Technician Telecommunications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Meni Important: If Item 27 is marked any injury or other traumatic e Ewald Meyer Elizabeth Trohs ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 559 Chestnut Hill Rd. Forest Hill, MD John C. Meyers / Son 20b. Place of Disposition (Name of Evans Funeral Chapel 20a. Method of Disposition 20c. Location - City or Town, State July 27 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 2009 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Forest Hill, Maryland 22. Name and Address of Facility Evans Funeral Chapel & Cremation Service—BelAir 21. Signature of Funeral Service Licenses 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or shock, or heart failure. List m lications II used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 □Yes 2**X**No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Son's Other: 4 Nursing Home 5 Residence XXOther (Specify) 1∐ Yes 2 🙀 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Home 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 🔀 Natural 5 Pending Injury

1 ☐ Yes 2 ☐ No

TC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

burial-transi and Box 68760, attending physician for use as the buria P.0. the ģ signed l Division of Vital Records, page 2 s has certificate Hospital or Attending Physician: this After 24 hours after death Funeral Director: filled in by

death with the Maryland

72 hours after

Pages \*

3altimore, Maryland 21215-0036

show

the ٥

State

Registrar

Medical

PITZLZP 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

2 Accident

4 Homicide

(Check only one)

3 Suicide

29a. Certifier

investigation

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined



PHYSICIAN

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 4:10 PMM Emily Jean Melville July 27, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Date of Birth (Month, Day, **Funeral** Year) Min. Days 1 □ M 2 🗷 F Months Hours 54 218-56-6900 Director May 15, 1955 Iowa Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, it a Medical Examinar mast be notified at 1 X Yes 2 □ No Director MD Montgomery Garrett Park 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code death with 1112 Kenilworth Ave. 20896 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, 72 hours after 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No Specify: þ 3 Widowed 4 Divorced Caucasian Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7: th and Mental Hygiene. ?7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Cleaner Custodial Work 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Seaman Melville Eleanor Vogel ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traum John Frederick Melville /Brother 2441 N. Forrest Park Ave. Gwynn Oak, MD 21207 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State Burt, Iowa 4 ☐ Donation 5 ☐ Other (Specify) Burt Municipal Cem. unknown 22. Name and Address of Facility Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Secuentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner burial-transi and that initiated events Box 68760,5 requires that the dath ertificate be execu resulting in death) Last Due to (or as a consequence of) physician Physician/Medical use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mg ō Dav 5 Other (specify) ed by the o 9 Unknown σ. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of death? The law 24a. Was an page 2 s autopsy perform certificate of Vital 1 □ Yes 2 🗌 No To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Nesidence} \) Residence \( 6 \) Other (Specify) 1 ☐ Yes 2 E M 2 ☐ FR/Outpatient 3 ☐ DOA this ( Certification: To 1 Inpatient After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation death. I Director: A 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined after 4 \( \text{Homicide} \) within 24 hours a 29a. Certifier 1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PIERSON MD 7503 SURRATTS RD CLINTON WENDELL

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

Registrar's Signature

			amer  1 - For State Registrar	od items 10 State of M		th g893 7 partment of ertificate o	7-31-09 vt Health and M			9 2463	
			Hegistrar     Name (First, Middle, La	st)		er tillcate o	Death	2. Date of Death	J. No.	3. Time of Death	
	Physic /Medi	cal	Janina Malis	zewski		T			3, Day 2009 Year	9:27 P M	
	Examii	ner	4a. Facility Name (If not institution, given Greater Baltimor	e Medical		Towso	50		4c. County of De	e	
	Funeral Director		101 31 1300	Sex 7. Ag	e (In yrs. last birthda Yrs.	Months   Day	/s Hours Min.	8. Date of Birth (Month, Day, ) Apr. 8,	rear) C	rthplace (State or Foreign Country) oland	
	ryland	_	Usual Residence of Decedent  10a. State 10b. County Ba	ltimore	10c. City, Town or	GLY	ndon			10d. Inside City Limits	
	the Ma 28a-f	recto	MD Fred	<del>lerick</del>		10f. Zip Code		100	g. Citizen of What C	1 ☐ Yes 2 No	
2	th with 23a or	al Di	14301 Green I	Road			1701	100	USA	ountry?	
raning 0036	after death with the Maryland or items 23a or 28a-f show miner rust be notified at	Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2. ☐	Ever in U.S. 13		of Hispanic Origin? (Speuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	ite, etc.	
003	ural",o	d by	3 Widowed 4 □ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:		1 □ Yes 2 🙀			Specify: W		
215	2 should be filed within 72 hours after dea and Mental Hygiene. Is marked other than "natural", or items raumatic event, The Maclical Econing.	Completed by Funeral Director	15. Decedent's Ed (Specify only highest grade) Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5	(Gi		cupation ne during most of workin ired) ss/Housek	ng	16b. Kind of Business/Industry  Service		
ASK land	ld be filed ental Hyg ked other ic event,	To Be C	17. Father's Name (First, Middle, Last, Wladyslaw		Bielewska						
SZCI	nd 2 shou lith and M 27 Is mar r traumati	-	19a. Informant's Name/Relationship ( Stanislaw Mal:		ber, City or Town, State, Zip Code) n, Maryland 21071						
Maliszewski Baltimore, Maryland 21	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Macical Examine. Thust be notified at once.		20a. Method of Disposition  1  Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specif	oc. Location - City o	r Town, State						
Balti	permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Licer	York Roakton, MD 2							
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	.Ces MOII	it,	Approximate Interval Between Onset and Death					
760, pg		ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):	Thro	mbus				
.O. Box 68	the d y the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Unknown		23d. Date of delivery  Month Day Year						
rds, P.	aw requires that s been signed b should be deta	þ	Part II. Other significant conditions of		, ^	1	given in Part I.			to the cause of death?  Probably 4 Unknown	
Division of Vital Records,	he law rec te has beer age 2 shou	Completed						24a. Was an autopsy performe	prior to ed?_ death?		
a	iysician; The iis certificate h director, page		25. Was case referred to medical				OS Diose of Double		No 1 ☐ Ye	s 2 No	
S	Physician: r this certifica ral director, p	) Be	examiner?	Hospital:	ent 2 ER/Outpati		26. Place of Death				
on of	iding Phys th. : After this : funeral dii	tion: To	27. Manner of Death  12. Natural 5 Pending 2 Accident Investigation	ce 6 ☐ Other (Sp injury occurred	ecify)						
Divisi	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	9	ury - At home, farm, s c. (Specify)		Yes 2 No	28f. Location (Stree City or Town, S	et and Number or F State)	Rural Route Number,	
	To the Hospita within 24 hours To the Funeral completely filled	Medical C	29a. Certifier (Check only one)  Certifying Ph	nysician: To the best on the basis on the basis on and manner sta	f examination and/or	ath occurred at the investigation, in m	time, date and place, a y opinion, death occurre	and due to the cau ed at the time, date	use(s) and manner e and place, and du	as stated. ue to the cause(s)	
	To th within To the	Me	29b. Signature and title of certifier	170		29c. Lice	nse number	29d	I. Date signed (Mor	th, Day, Year)	

15

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark GoShell 6535 N-Charles

31. Date filed (Month; Day, Year) 32. Destrar's Signature

park

Towson, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland Appeartment of Health and Mental Hygiene 2 1 1 2

		1- For Amend Item 19a per inf., 1894, 08707/09dhb Certificate of Death	2 Date	Reg of Death	j. No.		3. Time of De	nath
Physicia	ın	1. Decedent's Name (First, Middle, Last)	Mon		Day 2009	Year	10:00	
/Medic		Harry 01shansky  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of De-		20,	4c. County	of Death		alii
Examin	er	8 Joppawood Court Apt T1 Nottingham	alli		-		County	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H	in (Mor	of Birth oth, Day, \	Year)	9. Birth	place (State or F ntry) nsylvani	-
Director		Usual Residence of Decedent	Marc	11 12	, 1920			
a-f show	ctor	Maryland Baltimore County  10c. City, Town or Location  Nottingham					10d. Inside City	
3a or 28 If bendi	I Director	10e. Street and Number 10f. Zip Code 8 Joppawood Court Apt T1 21236		100	g. Citizen of W United		•	
penium ragas i fault and Mental Hygiene. Department of theath and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evanime must be notified if once.	by Funeral	11. Marital Status  1	(Specify Yes erto Rican, e	or No- tc.)	Black	e - Amer k, White, Whi		
n "natura Nedical J	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of w	working	16	5b. Kind of Bu	siness/Ir	ndustry	
Hygiene her than	Com	Elementary/Secondary (0-12) College (1-4or 5+) Meat Cutter  17. Father's Name (First, Middle, Last) 18. Mother's N	Jame (First I		arvest		r	
h and Mental h is marked of raumatic ever	To Be	Hyman Olshansky Anna	Rifki					
and I	-	19a. Informant's Name/Relationship (Type. Print)  Anita Marie Olshansky  19b. Mailing Address (Street and Number or	Rural Route	Number, (	City or Town,	State, Zi	ip Code)	
nent of Health ant: If item 27 ury or other tra	8	Anita Marie Otshansky Anita Marie Schott/Spouse  20a. Method of Disposition  1	Date	20	C. Location -	City or T	d 21236 own, State Pennsy	 Lva
Departme Importan any Injur		21. Signature of Funeral Service Licensee  22. Name and Address of Facility S  9705 Belair Road	chimun	ek F	uneral	Hom	e, Inc.	
as been signed by the attending physician and must be detached for use as the burial-transit and burial-transit burial-transit and burial-transit and burial-transit and burial-transit and burial-transit and burial-transit	Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, Language Cause (Disease or injury that initiated events resulting in death) Last  LARYNGEAL CANCE  Due to (or as a consequence of):  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  Due to (or as a consequence of):					Onset and De	
signed by the attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown			23d. Dat	te of deli	very Day Ye	ar
signed by	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	236				the cause of dea	
ate h	Completed	25. Was case referred to medical 26. Place of F	10		ed?	Were aut prior to d death? 1 ∐Yes	topsy findings av ompletion of cau	ailabl
is cert directi	To Be	25. Was case referred to medical examiner?  1 Yes 2 No   26. Place of D  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing				er (Spec	eify)	
h. After thi funeral	tion: T	27. Manner of Death  1 Natural 5 □ Pending  (Month, Day, Year)  28b. Time of Injury Work?  28c. Injury at Work?			v injury occurr			
s after death. Il Director: After this c ed in by the funeral dire	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		ation (Stre or Town,		er or Ru	ral Route Numbe	<i>∍r</i> ,
within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, to	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place. On the basis of examination and/or investigation, in my opinion, death or and manner stated.						
within To the comp	Me	29b. Signature and title of certifier 29c. License number 25 273 5	57		d. Date signe			
15		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  AMIT KHOSLA, MD 3901 THE ALAMEDA, B						
Sto	te	31. Date filed (Month, Day, Year)  32. Registrar's Signature			/			

# Baltimore, Maryland 21215-0036 Box 68760, P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician /Medical 4c. County of Death Facility Name (It not institution, give street and number, 4b. City, Town, or Location of Death Examiner UTWIN NOTE de 8. Date of Birth Month, Day, 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Months Hours Days 216-62-9290 1 X M 2 □ F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No **Funeral Director** More 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number , or items 23a or la Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 XÎNo þ Specify: 3 Widowed 4 Divorced ar "natural" Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) entral Parking n and Mental Hygin 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Brother) Department of Health ar Important: If Item 27 is any Injury or other trau 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 2009 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Joseph L. Russ Funeral Home, P.A.
2227 W. North Ave. Balto Md. 21216 21. Signature of Funeral Ser Approximate Interval Between Onset and Death 23a. P rt . Enter th : disease, or complications that caused the death. shock, or hear failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) / /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Ye ar Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part اللي **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 2 🗆 No 1 ☐ Yes 1 ☐ Yes Mother Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes a No Other: 4 Nursing Home 5 Residence Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) this 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 ☐ Yes 2 No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5

State Registrar

filed (Month, Day,

JUL 3 1 2009

Year)

1911

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State of Waryland / Department of Health and War Registrar Certificate of Death	Reg. 1	Bring and the and the state of
			1. Decedent's Name (First, Middle, Last)	Date of Death Month	3. Time of Death
	Physicia /Medic		I A ME I DE LE RELLE	July 3	30 2009 11:44AM
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	0 '	4c. County of Death
- April			Frankin Square Hospital Roseaule Foscial Social Soc	Data of Disti	Baltimore
	Funeral Director			Date of Birth (Month, Day, Yea )Ct 20,	9. Birthplace (State or Foreign Country) Maryland
	put w		Usual Residence of Decedent  10a, State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	f sho	ō			1 □ Yes 2 🙀 No
	28a-	rect	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country?
	3a or	Funeral Director	4501 F-Talcott Terrace 21128		U.S.A.
	death	ner	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specific Fig. 1)	fy Yes or No-	14. Race - American Indian, Black, White, etc.
036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. If Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "fedical Expriner rust ternofilial at	þ	a Specify: 1 Specify:	3411, 3131)	Specify: White
2-0	72 ho	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working		. Kind of Business/Industry
121	ithin ne. <b>han</b> "	jd m	Elementary/Secondary (0-12)  College (1-4or 5+)  Safety Training Supervis	sor	Steel
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and	uld be fi Mental I arked of atic ever	Be	Thomas Th	, , , , , , , , , , , , , , , , , , , ,	Muhlmueller
Ž	should and Mer s marke umatic	ဥ	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Fig. 19b. Mailing Address)	Route Number, Cit	
<u>8</u>	and 2 s ealth ar n 27 is ner trau		Janet Peterka-daughter 1419 Malvern Ave., Rux	kton, MD	21204
ē,	ges 1 an it of Hea if item 2 or other		20a. Method of Disposition 20b. Place of Disposition (Name of Date		. Location - City or Town, State
Ë	Pages nent of int: If Its iry or o		4 Donation 5 Other (Specify) Hilltop Serv Corp 7/31/	/09   To	owson, MD 21204
Baltimore, Maryland 21215-0036	permit. Pages Department of Important: If it any Injury or once.		21. Signature of Funeral Service Insee William G. Dau  22. Name and Address of Facility Ruck 1050 York Rd., Tows	Towson F	Funeral Home, Inc. 21204
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or r		Approximate Interval Between
	Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  a. CARDIOPULMOVARY  A.	RRES	Onset and Death
	/Medical		resulting in death)		
	Examiner		Sequentially list conditions,  b. ACUTE MYO CARDIAL IN	YFARC	7101
	ogit og	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.		
_	and Fran	Examiner	that initiated events resulting in death) Last  Due to (or as a consequence of):	_	
68760,	rificate be executed by physician and as the burial-transit				
687	tificate ig phys as the	<i>l</i> edical	d		
Box		N/M	IF FEMALE:  23c. If yes, outcome of pregnancy  23b. Was decedent pregnant  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of delivery
Ö.	The law requires that the death oe ate has been signed by the attendi page 2 should be detached for use	Physician/N	25. Was decelered regularity in the past 12 months?  1		Month Day Year
σ,	hat the set by detacl			23e. Did tobac	co use contribute to the cause of death?
ds,	uires that signed l id be det	d by		1 ☐ Yes	2 No 3 Probably 4 Unknown
Ö	w require been si should {	Completed		24a. Was an	24b. Were autopsy findings available
Re	sician: The law certificate has b irector, page 2 s	duc		autopsy	prior to completion of cause of death?  No 1 □ Yes 2 □ No
ā	an: T			1 ☐ Yes 2 ☐ Check only one)	TILL TES ZEINO
2	ysici is cer direct	o Be			e 6 ☐Other (Specify)
0	Attending Physician: sr death. ector: After this certific by the funeral director, I	T:u	27. Manner of Death 28a. Date of Injury 28b. Time of Injury Work? 28c. Injury at Work?	d. Describe how i	njury occurred
Ö	Attendin death. ctor: Af y the fur	atic	The Natural 5 Pending (Month, Day, Tear) Injury Work?  2 Accident investigation M 1 Yes 2 No		
Division of Vital Records,	al or Attend a after death I Director: d	Certification: To	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	Medical C		nd due to the caus d at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
	To the within To the comple	Me			Date signed (Month, Day, Year)
			Jasmus Uane MD 2006148	0	7/30/09
	10+11		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TASMIN UAN White Mo	ensh	7/30/09 MD 2/23C
	Sta Registr		a 31. Date filed (Month, Day, Year) 32. Hegistrar's Signature	-	1
	9.04				

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 Month **Physician** 222 P James Walter Persons, Jr. 27 July /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Franklin Square Hospital Rosedale Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 54 Yrs. Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1**X** M 2 ☐ F 213-64-5391 **Director** 8, 1954 Maryland Sept. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the life field at a recent of the life of t 1 XYes 2 No Director Maryland N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21215 3044 Tioga Parkway Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 \_Yes 2 \_ If Yes, Give Year or Dates: 2 No 1 Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐Yes 2 🛛 No Specify. ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dentist Office Dental Technician 4 Years permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygin Important: If Item 27 is marked other any injury or other traumatic event, It 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James W. Persons, Sr. Lillian Sconiers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3044 Tioga Pkwy Baltimore, Maryland 21215 Lillian Persons/ Mother 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/1/09 Woodlawn, Maryland Woodlawn Cemetery 22. Name and Address of Facility Chatman-Harris Funeral Home t useral Service Excens 21. Signatur 5240 Reisterstown Rd Baltimore, Md 21215 puris 234. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shook, or heart fature. List only one cause on each line. Imm te Cause (Fir al disease or condition resulting in death) 10 vassula **Physician** eriosc \*/Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physician and hed for use as the burial-transit Due to (or as a consequence of) O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 ☐ Unknown ٣. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate 1 □Yes 2 No 1 ☐ Yes the Hospital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Yes 2 □ No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X ER/Outpatient 3 ☐ DOA 1 Inpatient P this : After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier cal Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medi and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2 10. Name and address of perso 2. Registrar's Sig 31. Date filed (M onth, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Rodriquez 1: 45 AM Martha 27 July 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Dea **Baltimore City** The Johns Hopkins Hospital Year 1978 Birthplace (State or Foreign Country)
 To 1 8. Date of Birth (Month, Day, January 5. Social Security Number If Under 1 Year | If Under 24 Hrs. . Age (In yrs. last birthday HOnduras 216-67-8484 31 Yrs Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ¥ Yes 2 □ No Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code 3207 Fairmont Avenue 21224 H0nduras Was Decedent Ever in U.S Armed Forces? 1 Pes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Marital Status 1 X Never Married 2 Married 1X Yes 2 No Specify: Specify: White HOndurian 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Housekeeper Hotel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Orlando Rodriguez Maria Rodriguez 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lenin Alvarez (Fiance) B207 Fairmont Avenue Baltimore, MD. 21224 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date mcpal de Yoro. Ceme 708/4/2009 1X Burial 2 Cremation 3 Removal from State El Negrito, Yoro 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Santa Cruz Latino Funeral, Inc. 21. Sider ur = f Funeral Servi 600 Kennedy ST, NW, Washington, DC 20011 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CERGBRAL loxo PLASMOSIS disease or condition resulting in death) Due to (or as a consequence of) IMMUNODEFICIENCY VIRUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of)

**Physician** /Medical Examiner

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other it any injury or other traumatic event, the once,

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

Be

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**Funeral** 

**Director** 

er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

death with the Maryland

a 2 should be filed within 72 hours after thand Mental Hygiene.

Baltimore, Maryland 21215-0036

ician and burial-trans Division of Vital Records, P.O. Box 68760 the attending physician the use as been signed by page 2 should be filled in by the funeral director,

Examiner Be Completed by Physician/Medical ၉ Certification:

cal Medi

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown	23c. If yes, outcome of pregn 1   Live birth 2   Fet: 4   Pregnant at time of of 9   Unknown	al death 3 Ectopic			23d. Date of deliver Month	very Day Year
Part II. Other significant conditions of	contributing to death but not re	sulting in the underlying	cause given in Part I.			the cause of death?
				24a. Was an autopsy performed?	death?	topsy findings available completion of cause of
25. Was case referred to medical		_	26. Place of De	eath (Check only one)		
examiner? 1  Yes 2  No	Hospital: 1 Inpatient 2	ER/Outpatient 3 D	OA Other: 4 Nursing	Home 5 Residence	6 Other (Speci	ify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ury occurred	
3 Suicide 6 Could not be determined	28e. Place of injury - At he building, etc. (Specit		y, office	28f. Location (Street a City or Town, State		ral Route Number,
	nysician: To the best of my knominer: On the basis of examinating and manner stated.					

RES 000

State Registrar MARKANDAYA

completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

2009

MANJUNATH 31. Date filed (Month, Day, Year)

30. Name and address of person

certifier

29b. Signature and title

32. Registrar's Signature

within 24 hours after death.

To the Funeral Director: After to completely filled in by the tuner the Hospital or Attending

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 2009 July 28 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hopkins timos ahns 30/timore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, July 24 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Min. 1 M 2 F **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland D-partment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 res 2 No Director 10g. Citizen of What Country? 10f. Zip Code Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 □ ₩ If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Matthew Reese ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimor 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Lost Examiner The law requires that the death certificate be executed Partole physician and is the burial-trans CONTRACTION. resulting in death) Last Due to (or as, a cons quente of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) o. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Be Completed by 1 XYes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No page 2 s Pheumonia 1□ Yes 25. Was case referred to medical exampler? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2□ No Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division To the Hospital or Attending 1 Natural 5 Pending investigation Injury July 19,09 2113 death. 2 Accident neral Director: / 6 ☐ Could not be determined 3 ☐ Suicide 28e. P ace of injury - At home, farm, street, factory, office building, etc. (Spacify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after , Row Buildika Howe within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 28,2009 053250 3 30. Name and address of person who completed cause of death (Ifem 23a) (Type, Print) PURL Wertz 04145 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				For State Registrar		0.0.0	111017101		Certific			h	, , , , , , , , , , , , , , , , , , ,	Reg. No.	211119	24640
		Dhysiai		1. Decedent's Nam	e (First, Middle,	Last)						2	2. Date of De Month	eath Day	Year	3. Time of Death
	ľ	Physicia Medic/		Thomas J.	. Smith,	Jr.						(	07-27-	2009		1240 м
	A Company	Examin	er	4a. Facility Name (		_			4b. C	ity, Town, o		n of Death		4c.	County of Death	
	7					e Medica			If I in	Be1		er 24 Hrs.   s	D. D (D)		Harford	
		uneral irector		5. Social Security N 217-46-1	1783	i. Sex 1 [X] M 2 □ F	7. Age (In yrs		rs. Monti			Min.	3. Date of Bir (Month, Da 10-27-		9. Birth	place (State or Foreign Intry) MD
	and	WC T		Usual Residence of	10b. County		10c. C	ity, Town	or Location							10d. Inside City Limits
	Mary	r 28a-f show	ţ	MD	Baltim	ore		K-	ingsvil	11e						1 □ Yes 2 <b>X</b> No
	the .	or 28a s. noti	rec	10e. Street and Nu						Zip Code				10g. Citi	zen of What Cou	intry?
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	dea	ems	ner	11. Marital Status		12. Was Dece Armed Fo		J.S.	13. Was De	cedent of l	Hispanic (	Origin? (Spec can, Puerto Ri	ify Yes or No	D-	14. Race - Amer Black, White	
7)	ours after	Department of them 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examination once.	ρ	1 ☐ Never Marr 3 ☐ Widowed	ied 2 X Marrie 4 □ Divorced	d 1 X Yes If Yes, Giv Year or Da	2 □ No ⁄e			s 2 No					Specify: Wh	
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7	shoul nd M	mar	-	19a. Informant's Na	ame/Relationship	o (Type. Print)		19b.	Mailing Addr	ess (Street	·				r Town, State, Z	ip Code)
ÖŽ	ind 2	27 is		Ann A. S	Smith(Wi	fe)		70	000 Sur	nshin	e Ave	e King	gsvill	e, M	21087	
7	es 1 se of He	roth		20a. Method of Dis	position		20b.	Place of cemeter	Disposition (I	Name of or other pla	ice)	Da	te	20c. Lo	cation - City or T	own, State
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1 and 1	ermit.	Import any Inj once.		21. Signature of Fu	uneral Service Li	cen ee	h		22. Name	and Addre	ess of Fac	cility Schi	imunek	Fune	eral Hom	ne of BelAir
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أماد	\p <sub>e</sub>	ansit	Examiner	Sequentially list confidence if any, leading to implement cause. Enter Under Cause (Disease or that initiated events	rlying injury	540.07	or do d oorloo	4401100 0	.,,							
× × ×	exec	physician and the burial-transit	Exa	resulting in death) I	Last	c Due to (	or as a conse	quence o	f):							
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25	al or At	al Directed in by	Certification:	4 ☐ Homicide	determine	ed 28e. Place buildir	of Injury - At h ng, etc. <i>(Sp</i> ec	nome, far ify)	m, street, fact	tory, office		28	If. Location ( City or To	Street an wn, State,	d Number or Ru )	ral Route Number,
9	To the Hospital or Attend within 24 hours after death	To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical (	29a. Certifier (Check only one)	1 Certifying 2 Medical Ex	Physician: To the caminer: On the ba and mann	asis of examin	owledge ation and	death occuri	red at the t tion, in my	ime, date opinion, c	and place, ar leath occurred	nd due to the	e cause(s) , date and	and manner as place, and due	stated. to the cause(s)
	To the	To ti	Ž	29b. Signature and	title of certifier	17				29c. Licens	se numbe	r		29d. Dat	e signed (Month	, Day, Year)
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		Stat Registra	~	31. Date filed (Mon		109 Sept	or ucan (no	ature	barker	,		, , ,	-1- 11		Manual Total	· /

DHMH 17 Rev 1/2001

09-05792 Richard Loring St	eve		Type Stat	or Print in B e of Maryland	/ Depar	tment	of Health	n and Men	<b>opies Are L</b> tal Hygiene	egibl	e. 200	19 2464
		- For State			Cert	ificate	of Death	<u> </u>	2. Date of D	Reg. No	)	3. Time of Death
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Medical Examin		Richard L.  4a. Facility Name (if not ins			-\		4b City To	own, or Location			c. County of Death	1
1	В	3307 Betterton C		give street and number	,		Abingo			ļ	Harford	
Funeral	4	5. Social Security Number		Sex 7. A	ge (In yrs. las	st birthday)	If Unde	r 1 Year   If Unde	er 24Hrs. 8. Date of	Birth(MI	M/DD/YYYY) 9. Bir	thplace (State or
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Aaryla Aaryla 1389-f	Director	10e. Street and Number					10f. Zip	Code		10g. C	itizen of What Cou	intry?
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5-0036 iled within 7. Hygiene 1 other than		17. Father's Name (First, I	Middle, L	ast)					r's Name (First, Midd		en Surname)	
121 d be fi ental l arked	Be	Theodore N				10b Me	ilina Address	Joy (Street and Nu	C. Jacobs	Number	City or Town, Stat	e. Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other tranmatic event, the Medical Examiner must be notified at once.	٢	Richard L.		. ,					Cir Abir			1.3
, MD and 2 sho ealth and cen 27 is		20a. Method of Dispositio		Zenson, JI.	20b. F	Place of Dis	sposition (Nar	ne of cemetery,	Date	20	c. Location - City o	or Town, State
Baltimore, permit. Pages I ar Department of Her Important: If ite		1 X Burial 2 Cre	emation	3 Removal from	State		or other place)		07 20 20	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	70110400	MD
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O, e be e ysiciai burial	ledic	X UNPENDED		23c. If yes, out							23d. Date of delive	ery
Box 68760, e death certificate be the attending physic ed for use as the bur	sician/Medic	IF FEMALE: 23b. Was decedent pregn past 12 months?	ant in the			2	Fetal death	3 Ecto	pic pregnancy		Month	Day Year
x 6 th cer ittendi	icia	1 Yes 2 No 9	Unki		at time of de	eath 5	Other (Spe	ecify)		- 1		1
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ivisior or Attend after death Director:	ficat	2 Accident 3 Suicide 6	-	tigation 28e. Place of	of Injury - At h	nome, farm	, street, factor	y, office building		ition (Stre		Rural Route Number, City
Divi	Certification:	3 Suicide 6		mined (Specify)					0110	JWII, Stat		
Hospital 24 hours Funeral rtely filled		29a. Certifier 1 Cert	ifying Ph	ysician: To the best of	of my knowled	ige, death	occurred at th	ne time, date and	place, and due to the	e cause(s	s) and manner as s	tated.
Division of Vital Records, P.O. Box 68760, To the Inspital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death To the Fineral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burnal	Medical			miner: On the basis of and manner stat	examination a ed.	and/or inve					g place, and due to	
L 3 F 8	ž	29b. Signature and title of	of certifie	0			25	9c. License numb	er		29d. Date signed ( July 25, 2009	worth, Day, rear,
		4 - 1/2	to	The Une	u			O.C.M.E.			July 20, 2009	
y		30. Name and address of		who completed cause Assistant Medi			11 Penn S	treet. Baltimo	ore, MD 21201			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 2009 29 9:43 P M July 1 Schramm Irene Rhodel /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist Hospice Care If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Yea 12-3-1917 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🔽 F Yrs. Maryland 91 Director 216-01-6844 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location show Health and Mental Hygiene. em 27 is marked other than "natural" or items 23a or 28a-f show other traumatic event, the Medical Examinar must be multified at 1 ☐ Yes 2 X No Director Timonium Maryland | **Baltimore** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 21093 U.S.A. Funeral 10 Maymont Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 □ Yes 2 ▼No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 X No Specify: Specify. <u>۾</u> 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental Frankenberger Amelia Rader ဥ Cahrles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 3 Department of Health Important: If Item 27 any Injury or other tr. once. Timonium, Maryland 10 Maymont Court Fran Harris <u>Daughter</u> Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 8-3-2009 Baltimore Maryland Parkwood Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Road Towson, Maryland Magan lan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** UZAR disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or carry of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🗷 No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Vital Be ( 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) #OSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Division of this 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After it completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

Registrar

DANIEUR 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DUBGRMAN MO 6701 N CHAMESST, SUITE 4105 BALTIMIZE, MO 21204 32. Pegistrar's Signature

09-05908 Rot

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Physic	cian		. Decedent's Name (First, Middl	e,Last)			731		2.	Date of Death Month Duly 28, 200	ay Yea	.	Time of Death 0934 hrs	
dical Exan	nine		Robert Henry Sp				July 28, 200	4c. County of						
		4	4a. Facility Name (if not institution, give street and number) 600 Light Street, Apartment 836					4b. City, Town, or Location of Death  Baltimore  If Under 1 Year If Under 24Hrs. 8, Date of Birth (MM/DD/YYYY) 9, Birthplace (State or Foreign						
Funera	al	5	. Social Security Number	7. Age (In yrs. la	Age (In yrs. last birthday)				8. Date of Birth	(MM/DD/YYYY	9. Birthpla Countr	ace (State or Foreign		
Directo		2	219-38-3567   1XM 2 F   6			58 Yrs.		ays Hour	s Min.	06/15/1941 M			Maryland	
	7	_	Usual Residence of Decedent  10a State 110b County 10c. City, Town or Location									10	ld. Inside City Limits	
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72 hou	I Ex	Completed	Elementary/Secondary (0-12)	auring m	most of working life. DO NOT use retired)			u)						
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21215-0036 buld be filed within 7 lental Hygiene.	the		17. Father's Name (First, Middle Spar Joseph M. Spar	, Last)						First, Middle, M		=)		
121 1 be fi ental arked	vent,			n Address /	Street and N	umber or Ri	E. Thon	nas per. City or Tov	wn, State, Z	(ip Code)				
D 2 should and M is m	atic	٩١	19a. Informant's Name/Relation	Spangenber	erg g (Son)					ltimore				
Ore, MD 21215-0036 est and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f sho	E I	L	20a. Method of Disposition	- F 2	20b.	Place of Dispo	sition (Name o		Τ΄ -	Date	20c. Location	- City or To	own, State	
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timent trant:	0 or 0	1	Donation 5 Other S	Specify:			Name and Ad			ubbard H				
Bal permi Depar Impo	in in	- 1	21. Signature of Pulleral Service	e Licenson					Avenue	Balti	imore,	Maryl	and 21229	
Physicia	an	+	23a. Fart I. Enter the disease, o	or complications tha	t caused the death	h. Do not enter	the mode of d	ying, such as	cardiac or	respiratory arre	st, shock, or h	eart	Approximate Interval Between Onset and	
Medic		1	failure. List only one caus	se on each line.									Death	
camin	er	- 1	Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):											
		.	Sequentially list conditions, b.											
		ine	if any, leading to immediate  Due to (or as a consequence of):  Liter Underlying Cause											
. 3		Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):											
executed an and	- transit		d							<del></del>				
	burial -	edical	UNPENDED	AMENDE	D					_	-			
Box 68760, ne death certificate be e	the bu	₹ 	IF FEMALE: 23b. Was decedent pregnant in	Ale -	es, outcome of pre		etal death	3 Ecto	opic pregna	ncv	23d. Date Month	of delivery Da	ay Year	
certif	for use as the b	sician/M	23b. Was decedent pregnant in the past 12 months?  4 Pregnant at time of death 5 Other (Special Control of the								1			
Box e death the atte	d for 1	ıysi	1 Yes 2 No 9 L		known							talka da da di	and	
~ = £	<u>ੇ</u> ਦੂ	y Phy	Part II. Other significant cond	e underlying cause given in Part I. 23				e. Did tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 V Unknown						
ires that	5 5	d by						<u> </u>		24a. Was			opsy findings available	
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tal Reco cian: The law certificate has	2 61	E C									2 ✔ No	1 Yes	2 No	
<b>1.1</b>	director, page	C	25. Was case referred to medi				26	Place of Dea						
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of ing Pl	funeral	n:T	27. Manner of Death	28a. D (M	ate of Injury onth, Day,Year)	28b. Time o				28a. Describe	I. Describe how injury occurred			
ion tendi	the :	atio	1 V Natural 5 Pending 2 Accident Investigation					1 Yes 2 No			Street and Nu	mbor or Pur	ral Route Number, City	
Division of Vital Records, tal or Attending Physician: The law require and artifer dealh.	lin by	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, of						office building, etc. 28f. Location (Street and Number or Rural Route or Town, State)			ar reduce realized party		
Divis	filled	Cer	4 Homicide	etermined (Spec			1 - 1 15 - 17		d = l==== ====	due to the cau	co/c) and man	ner as state	ad .	
Divis  To the Hospital or A within 24 hours after	completely filled in by		29a. Certifier 1 Certifying one) 2 Medical E	Physician: To the	best of my knowled sis of examination	edge, death oc n and/or investi	curred at the ti gation, in my c	me, date and pinion, death	place, and noccurred	at the time, date	and place, an	d due to the	e cause(s)	
To th Within	сошр	Medical			ution, in my opinion, death occurred at the time, date			29d. Date signed (Month, Day, Year)						
		2	29b. Signature and title of cer	11 111			O.C.M.E.				July 29, 2009			
			30. Name and address of person who completed cause of death (item 23a)											
101	١,		30. Name and address of pers Pamela E. Southall		cause of death (it		111 Penn \$	Street, Ba	Itimore, I	MD 21201				
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		tate			2. Registrar's San	nature	1							

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Amend #3, 4cstate of Maryland Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 6:00 **Physician** 2009 ames 31 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore GOSSVIII & are anor Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 1 M 2 F Days Hours 41952 2\5-58-4463 Usual Residence of Decedent M 56 Director 10d. Inside City Limits 10c. City, Town or Location 10b. County :7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be rediffed at 1 Tes 2 No Director Aberdeer HarFord 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number #101 21001 USA May Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. If them 27 is marked other than "natural", or is any Injury or other traumatic event 1 ☐ Yes 2 ☐ No Maryland 21215-0036 Specify: 9 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) construction abover 1.9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) LIIRIE ILV )0. Ba 1+01 Druk Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State etro Cyanatory 21. Signature of Funeral Service. 22. Name and Address of Facility 18434 JESSUP, PA Mulvalley 1232 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Progressure declures my apart.

Due to or as a consequence of: Physician /Medical Due to (or as a consequence of): **Examiner** moderate to severe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed Cerebrovusculas and burial-trar Due to (or as a consequence of) attending physician Physician/Medical Dysphage as If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. the þ s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.
To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 sompletely filled in by the funeral director, page 2 sompletely filled in by the funeral director, page 2 sompletely filled in by the funeral director, page 2 sompletely filled in by the funeral director, page 2 sompletely filled in by the funeral director, page 2 sompletely filled in by the funeral director, page 2 sompletely filled in by the funeral director, page 2 sompletely filled in by the funeral director, page 2 sompletely filled in by the funeral director and page 3 sompletely filled in by the funeral director and page 3 sompletely filled in by the funeral director and page 3 sompletely filled in by the funeral director and page 3 sompletely filled in by the funeral director and page 3 sompletely filled in by the funeral director and page 3 sompletely filled in by the funeral director and page 3 sompletely filled in by the funeral director and page 3 sompletely filled in by the funeral director and page 3 sompletely filled in by the funeral director and page 3 sompletely filled in by the funeral director and page 3 sompletely filled in by the funeral director and page 3 sompletely filled in by the funeral director and page 3 sompletely filled in by the funeral director and page 3 sompletely filled in by the funeral director and page 3 sompletely filled in by the funeral director and page 3 sompletely filled in by the funeral director and page 3 sompletely filled in by the funeral director and page 3 sompletely filled in by the funeral director and page 3 sompletely filled in by the funeral director and page 3 sompletely filled in by the funeral director and page 3 sompletely filled in by the funeral director and page 3 sompletely filled in by the funeral director and page 3 sompletely filled in by the funeral director and page 3 sompletely filled in by the funeral director and page 3 sompletely filled in by the funeral dire autopsy 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No de 26. Place of Death (Check only one) Be Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28c. Injury at Work? 27. Manner of Death
Natural
2 Accident 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Nurse Practitioner 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RUS7625 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marcia Soulsman 6600 Ridge Road Baltimore, MD 21237 32. Registrar's Synature and 31. Date filed (Month, Day, Year) State JUL 31 2009

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year 07 2009 8:28 AM Helen S. Smith 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Parkville, Maryland If Under 1 Year | If Under 24 Hrs. | 8. Date Baltimore Quail Run Assisted Living Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours 1 □ M 2 🕱 F 12/05/1925 Maryland 83 220-18-8441 Usual Residence of Decedent 10d, Inside City Limits 10a. State 10c, City, Town or Location 1 ☐ Yes 2 X No Perry Hall Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 9906 Marilynn Road 21128 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 □Yes 2 No Specify: Specify: 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Esther Pearce Herbert Shanklin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9906 Marilynn Road - Perry Hall, Maryland 21128 of Disposition (Name of Date 20c. Location - City or Town, State Gail P. Smith (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fork U.M. Church Cem. 08/03/2009 Fork, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 21087 assaln 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last OBS RUCTIVE PULMONARY DISEASE IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 25. Was case examiner 1 ☐ Yes 27. Manner

Examiner be executed and burial-Box 68760, physician the as attending nse jo P.0. the signed by t Division of Vital Records, page 2 s has

**Physician** 

/Medical

Examine Physician/Medical þ Completed certificate Be this

**Physician** 

Examiner

Director

Funeral

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Completed

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**Funeral** 

**Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Example and Injury or other traumatic event, the Medical Example and Injury or other traumatic event.

Baltimore, Maryland 21215-0036

/Medical

Certification: To After this funeral of

Hospital or Attending 24 hours after death. filled in by To the Hosp within 24 hor To the Fune completely fi 20

29a. Certifier

(Check only one)

State Registrar

Medical

			-		24a. Was an autopsy performed?  1 □Yes 2 □No  24b. Were autopsy findings available prior to completion of cause of death?  1 □Yes 2 □No
Was case referre	d to medical			26. Place of De	ath (Check only one)
examiner?	6	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 D	OOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Other (Specify) ALF
Manner Death 1 Death 2 Accident	5 Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, street, factory)	ry, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

Maylet Place Dundalk MD 2/222

and manner stated.

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Charles Henry Stanley 2009 12:15 27. July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Greater Baltimore Medical Center Towson 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 88 215-12-0380 MARVIAND Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show important: If Item 27 is marked other than "natural", or items 23a or 28a4 shot any injury or other traumatic event, I'm Medical Exar, I'm rights by notified at 1 Yes 2 □ No Director BALTIMORE MD. 10g. Citizen of What Country? 10e. Street and Number 21224 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: BLACK Baltimore, Maryland 21215-003 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel RANE OPERATOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stanley Clara Harris ဂ္ nomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/225 19a. Informant's Name/Relationship (Type. Print) Cherry Hill Rd. BALTIMORE, MARY/AND position (Name of Date 20c. Location - City or Town, State Elizabeth Stanley WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages nent of I 1 Burial 2 ☐ Cremation 3 ☐ Removal from State woodlawn Cemetery (8/04/69 Gwynn OAK, Marykind 22. Name and Address of Facility The DEARICK C. JONES F/H, E 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 4611 PARK Hofs. Ave., BAltimore, MARVIAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardia /Medicai Due to (or as consequence of) **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) Box 68760 attending physician certificate be Physician/Medical the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 | Yes 2 | No 3 | Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 □ Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? **Hospital or Attending** Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. e Funeral Director: A 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar

(Check only

29b. Signature and title of certifier

within 2.

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

who completed cause of death (Item 23a) (Type, Print)

de istracio

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 30, 2009 11:27 A<sup>M</sup> Ju1y Marquerette /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Carrol1 Westminster Dove House | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, May 16, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1940 1 □ M **X**X F Virginia 220-36-1021 69 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show d other than "natural", or items 23a or 28a-f shore event, the McCical Examinar is ust be notified at 1 ☐ Yes XXNo Director Baltimore Reisterstown 10g. Citizen of What Country? 10e. Street and Number 21136 U.S.A. 105 Foxhaven Court Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ∐Yes **X**[X]No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes XX No Specify. Specify: White Completed by ¥¥Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Magnes. Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Waitress 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Adalade Jefferson Dillard Jennings 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sandy Harris / Daughter 105 Foxhaven Court, Reisterstown, MD 21136 20c. Location - City or Town, State 20a. Method of Disposition Date 20b. Place of Disposition (Name of cemetery, crematory or other of Cemetery, crematory or other place) Lakeview Memorial Park XX Burial 2 ☐ Cremation 3 ☐ Removal from State 8/4/09 Sykesville, MD 4 Donation 5 □Other (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Superat Solvice Licenses 11605 Reisterstown Rd. Owings Mills, MD21117 Golden 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ALUPE Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examiner physician and s the burial-trans Hospital or Attending Physician: The law requires that the death certificate be exec Due to (or as a consequence of): attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) as been signed by the 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? (Month, Day, Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records, P.O. Box  $68760^{<}$ within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

7

31. Date filed (Month, Day, Year) State Registrar

and title of certifier

29a. Certifier

29b. Signatu



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Mills

29c. License number

29d. Date signed (Month, Day, Year)

FLAVIO Kruter, MD

		1 - For Amend Item Registrar	23aPtl p	Marylander dr.,	d / Depa 8893 (	ortment of L	lealth a lhb Death	and Mental H	ygiene Reg. No. 2 ()	09 24648
Physicia /Medic		1. Decedent's Name (First, Middle, I	Last)	***	True	sdale		2. Date of D	Death Day S	3. Time of Death
Examin	er	4a. Facility Name (If not institution, s  The Johns Hopkins  5. Social Security Number 6	Hospital	. Age (In yrs. I	ast hirthday)	4b. City, Town, o <b>Baltimore</b> If Under 1 Year			4c. County	9. Birthplace (State or Foreign
Funeral Director		219–26–1551  Usual Residence of Decedent	1 <b>XX</b> M 2 TF	70	Yrs.	Months Days	Hours	Min. (Month, I	Day, Year)	County) Maryland
e Maryland 8a-f show ified at	ctor	10a. State 10b. County  Maryland Howard		10c. City	, Town or Loc	cation <b>lumbi</b> a				10d. Inside City Limits 1 ☐ Yes 2 🙀 No
th with the	al Director	10e. Street and Number 10361 Whitewasher	Way			10f. Zip-Code 2104/	4		10g. Citizen of W	ŕ
J30 Instant deal Instantion items  raminer mu	by Funeral	11. Marital Status  1 Never Married 2 XXMarried 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1	es? XX No	1	Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 🗓 No	lispanic Origan, Mexican Specify:	gin? (Specify Yes or N , Puerto Rican, etc.)	Black	e - American Indian, k, White, etc.
NOTE, MATYIANG ZIZIS-UU3O  ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		or 5+)	(Give life. L	dent's Usual Occup kind of work done DO NOT use retired	during mos	t of working		usiness/Industry
and A d be filed w intal Hygie ded other t event, the	Be	17. Father's Name (First, Middle, La Harry Dais Truesdal	st)	• • • • • • • • • • • • • • • • • • • •	Ai	anyst		er's Name (First, Mida	le, Maiden Surnam	
Maryis d 2 should th and Me th and Me traumatic	오	19a. Informant's Name/Relationship					and Number	er or Rural Route Nun Columbia, M	ber, Cify or Town,	
Dall Imore, permit. Pages 1 an Department of Heal Important: If item 2 any injury or other		20a. Method of Disposition 1XXBurial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		ate c	lace of Dispo emetery, cren	sition (Name of natory or other place	ce)	Date 7-25 - 2000	20c. Location -	City or Town, State
Daltimor permit. Pages Department of Important: If it any Injury or o		21. Signature of Funeral Service Lic			W- 5	Name and Addre itzke Funer 555 Twin Kr	ess of Facility Tal Hom Tolls R	es, Inc.	a. MD 21045	raryland
Physician /Medical		23a. P 1. Enter the dise se of the second seck, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	ly one cruse on each	vsed the death th line.	ory	er the mode of dyi	ng, such as	cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
Examiner ba isa	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		ras a consequence Art		ar Co	Maj	DE.		
vificate be executed g physician and as the bunal-transit	dical Exa	that initiated events resulting in death) Last	C	r as a consequ	-					
The law requires that the death certificate be executed at has been signed by the attending physician and page 2 should be detached for use as the bunial-transitions.	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No		th 2 Tetal	I death 3	Ectopic pregnand Other (specify)	су		23d. Dat Mor	e of delivery nth Day Year
uires that the signed by	by P	Part II. Other significant condition	s contributing to dea	ath but not res	ulting in the u	inderlying cause g	iven in Part		tobacco use cont	ribute to the cause of death?  3  Probably 4  Unknown
The law requires ate has been sign page 2 should be	Completed				•	· · · · · · · · · · · · · · · · · · ·		24a. Wa aut per 1 X Yes	opsy formed?	Were autopsy findings available prior to completion of cause of cleath?  Yes 2  No
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	n: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manuary of Death	28a. Date of		ER/Outpatien 28b. Time of Injury	1 3 DOA	ner: 4 □ Nu ryat	e of Death (Check only ursing Home 5  Re 28d. Describ		
or Attending after death.  Director; After in by the fune	ertification:	1 Autural 5 Pending 2 Accident investiga 3 Suicide 4 Homicide determine	t be 28e. Place o		me, farm, stre	1	Yes 2□	28f. Location	(Street and Numb own, State)	er or Rural Route Number,
Hospital 24 hours Funeral (	edical C	29a. Certifier (check only one) 1 Certifying 2 Medical E	Physician: To the be caminer: On the bas and manne	sis of examinat	wledge, death tion and/or in	occurred at the tivestigation, in my	me, date an opinion, dea	nd place, and due to the ath occurred at the time	ne cause(s) and ma ne, date and place,	anner as stated. and due to the cause(s)
To the within To the comple	Mec	29b. Signature and title of certifier	2/			29c. Licens	e number	)	29d. Date signed	1 (Month, Day, Year)
		Gregory	Rushing	of death (Iten		Print)		600 North W	olfe St, Ba	Itimore, MD, 21287
Sta Registr		31. Date filed (Month, Day, Year)  JUL 31 2	32 Heg	gistrar's Signat		Med				

DHMH 17 Rev 1/2001

			1- State Amend Item 27 per dr., 88936	Partment of Health and Northineath	/lental Hygi	iene eg. No. 2009	24649
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death July 25		3. Time of Death
	/Medic	al	Rajababu Veeramachaneni  4a. Facility Name (If not institution, give street and number)	4b. City. Town, or Location of Death	July 25	4c. County of Death	8:09 P M
	Examin	er	Franklin Square Hospital	Rosedale		Baltimore	
R	Funeral Director		5. Social Security Number 247-59-1852 6. Sex 1 ☑ M 2 □ F 7. Age (In yrs. last birtho	Months Days Hours Min	8. Date of Birth (Month, Day, 8/29/19	Year) 9. Birth Cou	place (State or Foreign Tndia
	land ow f		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town of the county	r Location			10d. Inside City Limits
	Mary Inc.	tor	MD Baltimore Parkvil	le			1 □Yes 2 No
	or 28	Director	10e. Street and Number	10f. Zip Code	10	0g. Citizen of What Cou	ntry?
	s 23a		9824 Britinay Lane  11 Marital Status 12. Was Decedent Ever in U.S.	21234	posific Voc. or No.	USA 14. Race - Amer	can Indian
336	should be filed within 72 hours after death with the Maryland of Mental Hyglene.  marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show marke event, it a Madical Examinar marker coffined at	by Funeral	11. Marital Status  1 □ Never Married 2√□ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No  If Yes, Give  Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	Rican, etc.)	Black, White,	
Baltimore, Maryland 21215-003	n 72 hou "natura	Completed	(Specify only highest grade completed)	ecedent's Usual Occupation Give kind of work done during most of work fe. DO NOT use retired)	ing	16b. Kind of Business/Ir	dustry
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D L	@ m @	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam			
<u> </u>	is 1 and 2 should be of Health and Mental item 27 Is marked or other traumatic every	욘	Somasankara Rao Veeramachaneni  19a. Informant's Name/Relationship (Type. Print)  19b. N	Prasunam  Mailing Address (Street and Number or Rui			n Code)
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ore,	es 1 a of He of Item or othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	isposition (Name of crematory or other place)	Date 2	20c. Location - City or T	own, State
Ĕ	t. Pages rtment of rtant: If it		4 □ Donation 5 □ Other (Specify) Hilltop	Serv. Corp. 7/28		Towson, Mar	
Bal	permit. Pag Departmen Important: any Injury once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility To Ruck Towson Funera			
			23a, Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
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	ed sit	iner	Sequentially list conditions, if any, leading to firmediate cause. Enter Underlying Cause (Disease or injury				
	execut n and al-tran	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of)	thritis			
8760	icate be executed physician and the burial-transit	dical	d				
29 X	ertifica ding pl	/Med	IF FEMALE: 220 If yes, outcome of programmy				
O. Box	w requires that the death certificate be executed to be executed to been signed by the attending physician and should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deli Month	<i>r</i> ery Day Year
Hecords, P.	requires that the peen signed by th hould be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tob	pacco use contribute to	
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VIta	siclan certifi irector	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	1 Other:	th (Check only on		<b>*</b> )
Division of	ng Phy fter this ineral d	on:To	27. Manner of Death  1 X Natural 5 Pending (Month, Day, Year)	ne of 28c. Injury at		ence 6 □ Other (Spec ow injury occurred	119)
<u> </u>	uttendi death. ctor: A y the fu	ertification:	2 Accident investigation	M   1 □Yes 2 □No	28f. Location (St	treet and Number or Ru	ral Route Number.
2	tal or A s after al Direct ed in by	Certif	4 ☐ Homicide	A-	City or Town		a riouto itamoon
	To the Hospital or Attending Physiclan: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director; t	edical (	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, Medical Examiner: On the basis of examination and/and manner stated.	death occurred at the time, date and place or investigation, in my opinion, death occu	, and due to the c rred at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
	Vithi Toth	Me	29b. Signature and title of contilior	29c. License number	1	9d. Date signed (Month	
			30. Name and address of person who completed cause of death (Item 23a) (To	100 63 9 (	55 0	7/28/2	009
	9		30. Name and address of person who completed cause of death (item 23a) (item 23a)	(pe, Print) Yric Road	hotre	ville Mr.	21093
	Sta Registr		31. Date filed (Month, Cay, Year)  32. Registrar's Signature  JUL 3 1 2009  JUL 3 4	and			

State of Maryland / Department of Health and Mental Hygiene 0 0 9

	1 - State Registrar	Cer	tificate of L	Death	Reg	. No.	1 N O O
	Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
ian cal	Gary Ivan Va	aughn				27, 2009	7:30 P
er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Death	
	107 Marley Neck Dr.			Glen Burnie			Arundel
	5. Social Security Number 6. Sex 7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	rear) Cou	place (State or Fore
		51 Yrs.			Aug 12	, 1957 AKO	MA YARK, M
	Usual Residence of Decedent  10a, State 10b, County 10c.	City, Town or Loc	cation				10d. Inside City Lim
ō	MD Anne Arundel	•		Glen Burnie			1 □ Yes 2
rect	10e. Street and Number		10f. Zip Code	Gleif Burnie		. Citizen of What Cou	untry?
Funeral Director	107 Marley Neck Dr.			21061		U.S	: A
era	11 Marital Status 12. Was Decedent Ever in	U.S. 13. V	Vas Decedent of Hi	spanic Origin? (Spe	ecify Yes or No-	14. Race - Amer	rican Indian,
	1 Never Married 2 Married 1 Yes 2 No		- 1	n, Mexican, Puerto	Hican, etc.)	Black, White	
<u>6</u>	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		☐Yes 2 No	Specify:		Specify: W	HIIL
Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	ient's Usual Occupa	uring most of workii		6b. Kind of Business/I	ndustry
du l	Elementary/Secondary (0-12) College (1-4or 5+)	life. I	OO NOT use retired,			_	_
ਨ	ATT TO A SALE OF THE A SALE OF		Heavy Equip	oment Opera 18. Mother's Name			bor
Be	17. Father's Name (First, Middle, Last)	La ca		10. Mouner a Marine	`		
유	Neil Edward Vaug  19a, Informant's Name/Relationship (Type. Print)		a Address (Street	and Number or Pure		Kate Roberts City or Town, State, Z	
	Sandra Kay Vaughn Spouse	1	_	Dr. Glen Bu			p Godey
			sition (Name of natory or other place			Oc. Location - City or 1	Town, State
	Burial 2 □ Cremation 3 □ Removal from State			i late	24 2000	Clan D	umia MD
	4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee		en Memorial P . Name and Addres		31, 2009	Gleff BC	urnie, MD
Physician/Medical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate clause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions contributing to death but not	gnancy retal death 3 of death 5	□Ectopic pregnanc; □Other (specify)	2	23e. Did toba	23d. Date of del Month	Day Year
d by					1X Yes	; 2 □ No 3 □ Pr	obably 4 ☐ Unkno
ompleted					24a. Was an autopsy perform	prior to death?	utopsy findings availa completion of cause
C	25. Was case referred to medical			26. Place of Death		1	
To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	2 ☐ ER/Outpatier	nt 3 DOA Othe	er: 4 🗆 Nursing Ho	me 5 Resider	nce 6 Other (Spe	cify)
Certification:	27. Manner of Death 1 Natural 5 Pending 20 Accident investigation 3 Suigide 6 Could not be		M 1	? Yes 2 □ No	28d. Describe how		,
ertifi	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Sp	nt nome, farm, str ecify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ural Houte Number,
edical C	29a. Certifier (Check only orie)  1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of exam and manner stated.	knowledge, deat nination and/or in	h occurred at the tire tire tire to the ti	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manner as te and place, and due	s stated. e to the cause(s)
₩	29b. Signature and title of certifier		29c. Licens	e number	29	d. Date signed (Monta	h, Day, Year)
	> ( Manhay M.D			39505		July 28	8,2009
	29a. Certifler  (Check only 2 Medical Examiner: On the best of my end manner stated.)  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Month, Day, Year)  31. Date filed (Month, Day, Year)  32. Figure Signature	Item 23a) (Type,	Print) bital D	v. Glen	n Bun	ie, M	D. 2106
ate rar	31. Date filed (Month, Day, Year) 32. Fight ar's Si	gnature	and I				

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 400 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** July 28 William Brice Whitmore, Sr. 2009 9:15 Α /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 6. Sex **Funeral** 1 X M 2 □ F Months Days Hours 578-18-2365 89 June 27, 1920 Washington, D.C. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be rottlied at once. 1 ☐ Yes 2 ☑ No Director Maryland Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11264 Putnam Road 21788 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electronics Technician Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willard Wert Whitmore Helen Frances Brice ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Brice Whitmore, Jr./Son 11264 Putnam Road, Thurmont, Maryland 21788 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State July 31, 2009 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland Gate of Heaven Cemetery Robert A. Pumphrey Funeral Home/Rockville, Inc. 21. Signature of Euneral Service Licensee Butte M01548 B00 West Montgomery Avenue, Rockville, Maryland 20850 23a. Part 1. Enter the diseas or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Shock **Physician** disease or condition resulting in death) scoti ( /Medical Due to (or as a consequence of): Examiner potension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine PENNSTEMIA Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> en fews ion 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 26. Place of Death (Check only one)

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, P.0. Division of Vital Records, After this

Baltimore, Maryland 21215-0036

ours after death.

Ieral Director: A
filled in by the fu death.

Be Medical Certification: To

within 24 hours a

10+1

State

Registrar

25. Was case referred to medical examiner?

1 Yes 2 No 27. Manner of Death Natural 2 Accident 5 Pending

3 ☐ Suicide

29a. Certifier

6 ☐ Could not be determined 4 Homicide

investigation

Hospital: Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

Dv.

DHIIEF WD

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

29d. Date signed (Month. Day. Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Germanteun MD 20874

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ZantimD 19529 Doctors

and manner stated

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

JUL 31 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-05874 State of Maryland / Department of Health and Mental Hygiene Joseph Wellington Certificate of Death Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Year JUSEPH Wellington 1233 hrs Medical Examiner July 27, 2009 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 601 Wyanoke Avenue, Apt. 320 Baltimore 9. Birthplace (State or Foreign Worth If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Director Country) Cardlina 211-07-0298 1 V M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10b. County Bultimore Yes 2 Maryland death with the Maryland Director 10g. Gitizen of What Country? 10e. Street and Number 10f, Zip Code 21218 Knited WYANOKE or items 23a onust be notif Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marjtal Status 12. Was Decedent Ever in U.S If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married 2 Yes Black hours after f Yes, Give Year 2 V No Specify Yes specify: Widowed Divorced ş 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) other than "t 72 ONVENIER Baltimore, MD 21215-0036 Entreprenuer t. Pages 1 and 2 should be filed within trnent of Health and Mental Hygiene. 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Mary King marked Wellington Be 10580h 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is Wellington-Daughter 4604 Shamrock Avenue Baltimore, MD. 21206 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Owings Mills, Maryland Burial 2 Cremation Garnson Forest Veterans 2009 portant: Donation 5 Other Specify annume and Address of Familians Funited 210 Fredhillon Pass Bult g ature of Funeral Service Licensee en Bultimore, Marsland 2/209 ni L. Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Division of Vital Records, P.O. Box 68760, rat or Attending Physician: The law requires that the death certificate be executed Physician/Medical signed by the attending physician be detached for use as the burial -UNPENDED AMENDED 23d. Date of delivery IF FEMALE: 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 ✔ Unknown Chronic alcohol abuse Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? Yes 2 No Yes No e Hospital or Attending Physician: 24 hours after death. 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other 4 Residence 6 V Other: Scene Nursing Home 5 Inpatient 2 ER/Outpatient 3 DOA After this 1 V Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 V Natural Yes 2 Pending To the Funeral Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 🗸 and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier July 28, 2009 O.C.M.E

Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Patricia Aronica-Pollak MD. 31. Date filed (Month, Day, Year

111 Penn Street, Baltimore, MD 21201

State Registrar

State Registrar 29a Certifier

31. Date filed (Month)

29b. Signature and title of certifier

612AW H.

GIZAW WOLDEHINOT,

Day,

WOUDEHOUT

MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

1 Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

10063327

9000 FRANKLIN Sq. DR. BALTIMORE, MIS

29d. Date signed (Month, Day, Year)

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 24654 State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) nay 09 Bowens 1210 M **Physician** 21 Thomas Lzalua /Medical 4c County of Death 4b. City, Town, or Location of Death 4a. Facility Name-of not institution, give street and number Examiner Prince Georges Hospital Prince Georges Cheverly If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F NONE  $\bigcirc$ Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heatth and Mental Hygiene.
ant: If item 27 le marked other than "neturel", or Items 23a or 28e-1 ehow 1ry or other treumatic event, the Modical Extening must be recitived at Prince Georges 1 XYes 2 No District MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Mace Overdale 20747 Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 🗆 Yes 2 🗖 No Black Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Infant 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bowens UNKNOWN atese. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2705 Overdale Pl. District Heights, MD 20147 atese Bowens Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) HOSD DISOOS PGHC 22. Name and Address of Facility
Prince Georges Hospital Center
3001 Hospital De. Chevery, HD 21. Signature of Funeral Service Linens Marie 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prematuri Extreme disease or condition resulting in death) Due to (or as a consequence of): Hemorrhage Intraventricular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit Kespirator Due to (or as a consequence of) Physician/Medical IF FEMALE: within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 PNo 3 Probably 4 Unknown 1 Yes Be Completed

**Physician** /Medical **Examiner** 

death with the Maryland

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

or Attending Physician:

24a. Was an autopsy performed

2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Hospital: 1 Impatient 3□ DOA 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Injury 2 No 1 Tyes

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier mennue Asedon

1)2818

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Drive Cheverly 3001

State Registrar

Medical Certification: To

31. Date filed (Month; Day, Year) AUG 0 3 2009

5 Pending

investigation

6 Could not be determined

25. Was case referred to medical

2 No

examiner?

1 Tyes

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 | Homicide

62. Registrar's Signature

within 24 hours a To the Funerel I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 3:00 PM nerald Carrick 0.7 29 P005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baitinore 22 South Breeze BEHINNIN MD Z)ZC 1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1/1 M 2 □ F Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) Date of Birth (Month, Day, **Funeral** Days Hours (Month, Day, Year) September 24, 1941 220-38-5100 67 Maryland Director Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov 1 ☐ Yes 2 No Director Maryland Baltimore Sparrows Point 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21219 14 Barbara Lane USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 "natural", or <u>ک</u> 1∐Yes 2∏Wo Specify: Specify: White 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd 2 should be filed within 7 aith and Mental Hygiene. 27 is marked other than "r traumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) <u>12 years</u> Machinist Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic ev Frank Peter Carrick Mary Frances McNamara 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Carrick wile 14 Barbara Lane, Sparrows Point, Maryland 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition August 3, 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 Dundalk, Maryland Name and Address of Facility Lome of Dundalk, P. A. sign ture of Funeral Service Licensee 7110 Sollers Point Road, Dundalk, Maryland 21222 23a. Part 1. Enter the disease, complications that caused the death, on one enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Immediate Cause (Final **Physician** Hyperic Respiratory Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner dasopressor unrespensive Sequentially list conditions, Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760. physician Physician/Medical the as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) □Yes 2□No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Not small cell lung corcer Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has Exprayeral Mass page 2 autopsy perform this certificate 2 **X** No 2 No 1 □ Yes 1 Tyes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After thi funeral ( 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Injury at Work? 28c. 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Medical (Check only one)

P.0. Records, of Vital Division To the Hospital

> Andrew Walker, M.D 22 South Greene Street, 31. Date filed (Month, Day, Year) 32 Registrar's Signature State AUG 03 Registrar

29b. Signature a



and manner stated.

m.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

1679708788

Bultimore MD 21261

29d. Date signed (Month, Day, Year)

29/2009

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 Caldarazzo 20 AM Henry 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Months Days 213-32-4278 Pennsylvania October 6, 1934 74 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2X No Baltimore Dundalk Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code USA 21222 204 Robwood Road 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Technical Illustrator Self Employed 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sarah Galeano Frank Caldarazzo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1407 Rosewick Avenue, Rosedale, Maryland Henry Caldarazzo Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State August 1, 20c. Location - City or Town, State Baltimore, Maryland 2009 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 22 Name and Address of Facility Connelly Funeral Home Of Dundalk, P. A. ergnature of Fyneral Service License 7110 Sollers Point Road, Dundalk, Maryland 21222 23a. Part 1. Enter the disease or heart failure. Ilist complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): gnancy 23d. Date of delivery etal death 3 Ectopic pregnancy Month Day 5 Other (specify) of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Nes

**Physician** /Medical Examiner

Physician

/Medical

Examiner

10a. State

Director

Funeral

þ

Completed

Be

ဂ

**Funeral** 

**Director** 

28a-f show

or items 23a

"natural",

al Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item Z7 is marked othing any injury or other traumatic event, one.

traumatic event, the Medical Examiner must be notified at

with the Maryland

within 72 hours after death

Baltimore, Maryland 21215-0036

burial-trar the as nse page 2 should

or Attending Physiclan: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medical þ Completed Be မ Certification: the

2

FEMALE: 3b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of pre

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

24a. Was an autopsy performed 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 🗌 No

	25.	Was case examiner 1 \( \subseteq \text{Yes}	? /	d to medical o
I	27.	Mann r o		5 ☐ Pendir

Pending investigation Could not be

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 2 🗌 No 1 TYes

28d. Describe how injury occurred

26. Place of Death Check only one

29a. Certifier (check only

2 Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number Kes-000 29d. Date signed (Month, Day, Year) 29 2009

600 North Wolfe St, Baltimore, MD, 21287

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

32/Registrar's Signature

State Registrar

Director: After

filled in by

Medical

after death.

24 hours

within 2 To the F

backs

	1	For State Registrar		State of M	aryland		artment <i>rtificate</i>			nd Mei		giene leg. No	000	9 2	4657
		1. Decedent's Name (F		ast)							Date of Dea Month		y Yea		ime of Death
ysicia: /ledica		Elizabet	h				Craig				Month uly		, 2009		0:34A M
amine		4a. Facility Name (If no	_		)				Location of	Death			. County of De		
		7843 Cre			(la la	a t histholass	Cu:		Bay	4 Hrs. I a	Date of Birt		Anne Ar		State or Foreign
eral ctor		5. Social Security Num		Sex 7.A 1 □ M 2 <b>XX</b> F	ge ( <i>In yr</i> s. la 78	Yrs.	Months	Days	Hours	Min.	Date of Birt (Month, Day	Year)		Country)	arolina
(OI		246-44-7896 Usual Residence of De			70						11y 1/	<b>9</b> 1.	751 1101		
İ		10a. State	0b. County		10c. City,	Town or Lo	cation								side City Limits
	i cto	MD A	Anne Ar	undel	Curt	is Ba	У							1	□Yes 2/1XNo
	ē	10e. Street and Number	er				10f. Zip					- 3	tizen of What	Country?	
	<u>e</u> [	7843 Creek	Shore	Way	***			226				USA			
	Funeral Director	11, Marital Status		12. Was Decedent Armed Forces 1 ☐ Yes 2☐	t Ever in U.S ?	. 13.	Was Decede If Yes, speci	ent of Hi ify Cuba	ispanic Orig ın, Mexican,	jin? (Specif Puerto Ric	y Yes or No- an, etc.)		14. Race - Al Black, Wi		dian,
	D F	1 ☐ Never Married  3 Widowed 4 D	_	1 ∐ Yes 2\\ If Yes, Give Year or Dates:			1 □Yes 🖁	No KI	Specify:				Specify: ]	Black	
1	80		5. Decedent's E			16a Dece	dent's Usua	Occupa	ation			16b. K	(ind of Busine	ss/Industry	
	Set	(Specify	only highest gi	rade completed)		(Give	kind of worl	k done d e retired	during most ()	of working	-Ĭ			,	
	Completed	Elementary/Seconda	ary (0-12)	College (1-4or 2	5+)	_	cretar					U	.S. Arı	my	
	Be C	17. Father's Name (Fir	st, Middle, Las	t)					18. Mother	's Name (F	irst, Middle,	Maider	Surname)		
		Carson P	rice					ŀ	Trumi.	11a	Mitch	e11			
ď		19a. Informant's Name	e/Relationship	(Type. Print)		19b. Maili	ng Address	(Street	and Numbe	r or Rural F	Route Numbe	er, City	or Town, State	e, Zip Code	?)
	3.	Ms. Norma'	Terry /	Daughter		7843	Creek	c Sh	ore Wa	ay, (	Curtis	Ba	y, MD	21226	
		20a. Method of Dispos		☐ Removal from State	20b. Pla	ace of Dispo	sition (Nam	e of her plac	е)	Date	i	20c. L	ocation - City	or Town, S	tate
		1 ☐ Burial 27424 4 ☐ Donation 5			3 1 .		Crema		, 0	/5/200	09	Gle	n Burn	ie, M	D
ouce.		21. Signature of Fune	ral Service Lice	ensee	'								eral &		
3		23a. Part 1. Enter the	ر مر کر	-31		7 4 7 1					-		len Bu		MD 2106
in al er	Examiner	shock, or heart fi Immediate Cause (Fir disease or condition resulting in death)  Sequentially list condi- if any, leading to imme cause. Enter Underly Cause (Disease or inji that initiated events resulting in death) Las	tions, addate	a. Due to (or a b. Due to (or a c.	line.	nerce of):	's D								val Between et and Death 55 4 Y 5
	Physician/Medical	IF FEMALE: 23b. Was decedent print the past 12 mr 1 □ Yes 2 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	onths?	d	2 Fetal at time of de	death 3	⊒ Ectopic pr ⊒ Other (sp		у				23d. Date of Month	Day	Year
- 12	2	Part II. Other significa	ant conditions	contributing to death	but not resu	ting in the u	inderlying ca	ause giv	en in Part I.		_		use contribute 2 ☐ No 3 ☐		4 🔣 Unknown
	×										24a. Was autop	sy	prior	to complet	ndings available ion of cause of
	npletec														No
	Completed										perfo 1 □ Yes		o death	res ZL	
	Be Completed	25. Was case referred examiner?	d to medical		-11-11					of Death (		2 A N		res 2U	
	To Be	examiner? 1∐ Yes 2 <b>X</b> No			tient 2 🗆 l				er: 4 □ Nu	rsing Home	1 □ Yes  Check only of  5 ■ Resid	2 N ne) dence	6 ☐ Other (£		
	To Be	examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 2 ☐ Accident		28a. Date of Ir (Month, D	ijury Day, Year)	28b. Time of Injury	of 2	8c. Injur Worl	er: 4 □ Nu	rsing Home 280	1 □ Yes  Check only of  5 ■ Resid. Describe I	2 AN ene) dence now inju	6 Other (Surry occurred	Specify)	ite Number,
	Certification: To Be	examiner?  1 Yes 2 No.  27. Manner of Death  1 Notural  2 Accident  3 Suicide  4 Homicide	5 Pending investigation 6 Could not determine	28a. Date of Ir (Month, D	njury Day, Year)  njury - At hosetc. (Specify  st of my know	28b. Time of Injury  me, farm, st	M 2:	8c. Injur Worl 1 🗆 ; office	er: 4 □ Nu ry at k? Yes 2 □ I	rsing Home 286 No 286	1 □ Yes  Check only of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the Sta	2 None)  dence how inju	6 Other (Sury occurred	Specify)  r Rural Rouer as stated	,
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led in by the funeral director, page z should be d	Certification: To Be	examiner?  1 Yes 2 No.  27. Manner of Death  1 Natural  2 Accident  3 Suicide  4 Homicide  29a. Certifier (Check only one)	5 Pending investigation of Could not determine  Certifying F Medical Exit	28a. Date of Ir (Month, E)  28a. Date of Ir (Month, E)  28e. Place of Ir building,  Physician: To the besaminer: On the basis	njury Day, Year)  njury - At housetc. (Specify  st of my know of examinat	28b. Time of Injury  me, farm, st  vledge, dealion and/or i	of 2.  M reet, factory, th occurred investigation,	8c. Injury World	er: 4 Nu y at k? Yes 2 I me, date ar opinion, dea	rsing Home 286 No 281 and place, and th occurred	1 □ Yes  Check only of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the Sta	2 None)  dence now inju  Street a vn, Stat  cause( date ar	6 Other (Sury occurred	Specify)  r Rural Roter as stated due to the lonth, Day,	cause(s)

DHMH 17 Rev 1/2001

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AMEND ITEM#18perffl, G894, 8/10709, WS
State of Maryland / Department of Health and Mental Hygiene

			1 - State of Maryland* Dep	ertificate of		-	giene Reg. No. 2	9 24658
	Physicia		1. Decedent's Name <i>(First, Middle, Last)</i> Katherine K. di Giro	ol amo		2. Date of Dea Month July	28, 2009	3. Time of Death 9:24 PM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		r Location of Death	[ J 41 ]	4c. County of De	
			Raphael House		ville	,	Montgo	
I	Funeral Director		5. Social Security Number 6. Sex 1 M 2 M F 7. Age (In yrs. last birthda) 93 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da January	<sup>th</sup> Year) 9. E 23, 1916 In	Birthplace (State or Foreign Country) ndiana
	land ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	ocation				10d. Inside City Limits
	a-fsh	ctor	Maryland Montgomery Bethes	da				1 □Yes 2X No
	or 28	Dire	10e. Street and Number	10f. Zip Code			10g. Citizen of What	Country?
	s 23a	eral	9607 Parkwood Drive	208			United St	
15-0036	be filed within 72 hours after death with the Maryland and Hygliene. And delthyliene. dother than "natural", or items 23a or 28a-f show edent, the Marical Examination and the indifficult event, the Marical Examination and the indifficult and the marical Examination and the indifficult and the marical Examination and the indifficult and the marical Examination and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and the indifficult and	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ★ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ★ No If Yes, Give Year or Dates:	. Was Decedent of H If Yes, specify Cuba 1 □Yes 2ሺNo	lispanic Origin? (Sp an, Mexican, Puerto Specity:	ecify Yes or No Rican, etc.)	_	merican Indian, hite, etc. ∛hite
<u>۔</u>	72 hc "natur	letec	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occup e kind of work done DO NOT use retired	ation during most of work	ing (	16b. Kind of Busines	ss/Industry
7	12 should be filed within 1 h and Mental Hygiene. 7 is marked other than " raumatic event, the Mex	Completed	Elementary/Secondary (0-12)   College (1-40r 5+)	DO NOT use retired nemaker	1)		Own Hor	me
שנ	e filed al Hygi other /ent, I	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Name	e (First, Middle,	Maiden Surname)	
yland	wild be Menta arked atic ev	To E	John Jacob Kern		Mary Fr	ances 4	rott	
Mar	2 sho h and 'is ma rauma	ľ		-			er, City or Town, State	
		_ 1	Patricia L. O'Connell /Daughter 9607  20a. Method of Disposition 20b. Place of Disp			ethesda <sub>Date</sub>	, Mary Land	
baitimor	permit. Pages 1 and Department of Healt Important: If Item 2: any Injury or other once.		4 □ Donation 5 □ Other (Specify) Rock Cre	osition (Name of ematory or other place ek Cemete	ry 20	ost 3,	Washington	n, D.C.
e D	permi Depa Impo any Ir		21. Signature of Funoral Service Licensee  M01305  R 7	22. Name and Addre obert A. Pun 557 Wisconst	ss of Facility Iphrey Funer In Avenue, E	al Home/ Bethesda,	Bethesda-Che Maryland 208	evy Chase, Inc. 314-3501
	Physician		23a. First 1 Anter the disease, or complications that caused the death. Do not eshoot or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition Coronary Artery 1		ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	/Medical		resulting in death)  a. Due to (or as a consequence of):	200000				
	Examiner	_	Sequentially list conditions, Chronic Obstruct	ive Pulmo	nary Dise	ease		
	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
5	exect an and ial-tra	Еха	that initiated events resulting in death) Last C Due to (or as a consequence of):					
00/00	ificate be executed g physician and as the burial-transit	edical	d					
O. DOX 0	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  within 24 hours after death.  completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me		☐ Ectopic pregnand ☐ Other (specify) _	у		23d. Date of Month	delivery Day Year
ecords, r	quires that en signed b uld be deta		Part II. Other significant conditions contributing to death but not resulting in the Hypertension, Aortic Valve Disorder		en in Part I.			e to the cause of death?  Probably 4 🕅 Unknown
n reco	: The law re cate has be page 2 sho	Completed by		<del></del>		24a. Was autop perfo 1 □ Yes	osy prior rmed? death	autopsy findings available to completion of cause of
<u> </u>	siclan certifi rector,	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	Oth	26. Place of Deat			
0 00	y Phys er this eral di	7: To	27. Manner of Death 28a. Date of Injury 28b. Time		4 X Nursing Ho		dence 6 Other (S	Specify)
5	inding ath. r; Afte re fune	atio	1 X Natural 5 □ Pending (Month, Day, Year) Injury 2 □ Accident investigation		ć? Yes 2 □ No			
DIVIS	al or Atte s after dea al Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office		28f. Location (; City or To	Street and Number or vn, State)	Rural Route Number,
	ne Hospit n 24 hour ne Funera	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the ti investigation, in my o	me, date and place, ppinion, death occur	, and due to the red at the time,	cause(s) and manne date and place, and d	r as stated. due to the cause(s)
	Vithii Vithii Comp	Me	29b. Signature and title of certifier  J: Kouertchou, mD	29c. Licens			29d. Date signed (Mo	
			) routerned; mis	D006	3748		July 29,	2009
			30. Name and address of person who completed cause of death (Item 23a) (Type Jocelyne Kouatchou, M.D. 6001 Munca		Road, Ro	ckville	, Maryland	d 20855
	Sta Registra		31. Date filed (Month, Day, Year)  AUG 0 3 2009  32. Registrar's Signature	Les .				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** ANITA M. GENTILE /Medical 4c. County of Death or Location of Death Facility Name (If not institution, give street and number) 4b. City, Town, Examiner N/A Birthplace (State or Foreign Country) If Under 24 8. Date of Birth (Month, Day, Year) JULY 28,1921 . Age (In yrs. last birthday, 5. Social Security Number **Funeral** Days Min 1 □ M 2√2 F NY 87 Director 219-05-1212 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f show 1 ☐Yes 2 ☐ No **Funeral Director** BALTIMORE MD N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21212 125 E. MELROSE AVE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11, Marital Status Black, White, etc. Armed Force 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify Specify WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", any july or other traumatic event, the Medical Exagnes. 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RETAIL SALESPERSON 10TH Baltimore, Maryland 21 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ELSIE MORCH JAMES HOBSON ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BALTIMORE, MD 21206 BARBARA GENTILE-DAUGHTER IN LAW 3815 WOODLEA AVE 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PARKWOOD CEMETERY 7/31/09 BALTIMORE, MD MILLER-DIPPEL FUNERAL HOME, INC 21. Signature of Fune al Service Licenses 22. Name and Address of Facility BALTIMORE, MD 21206 6415 BELAIR RD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Hear+ **Physician** concestive disease or condition resulting in death) /Medical Due to (or 🍌 a consequence of Examiner emphysema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) P.0. the 9 Unknown s been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has briector, page 2 s performed 1 ☐Yes 2 ☐ No 1 ☐Yes 2 🔽 To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA င္ After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu · death. investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1393064 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 14 per 1h g894 8-4-09 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2009 13:33 JULY 30 CARROLL NAYLOR HINTON, JR. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE RANDALLSTOWN FUTURE CARE - OLD COURT Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 **X**M 2 □ F Yrs JUNE 26,1925 MD 84 217-76-6040 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show traumatic event, the Midical Examinar must be notified at 1 XYes 2 No Director PIKESVILLE BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö USA 4131 BALMORAL CIRCLE 21208 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. items 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married WHITE Saltimore, Maryland 21215-0036 þ 1 ∐Yes 2**X** No Specify þ BLACK 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) NEVER WORKED 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ELEANOR BURNHAM CARROLL HINTON ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health Department of Health Important: If item 27 any Injury or other tra BALTIMORE, MARYLAND 21215 MARLENE HALL/CAREGIVER 4814 SETON DR. 20c. Location - City or Town, State 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 8-4-2009 BALTIMORE, MARYLAND METRO CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., LNC. 21. Signature of Funeral Service Licensee 1701-31 LAURENS ST. BALTIMORE, MD 21217 a. ron 23a. Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Vaeulas direct Atherosclero Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transi and Due to (or as a consequence of): attending physician for use as the burial O. Box 68760, certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 5 Other (specify) been signed by the should be detached 1 □Yes 2 □No 9 🗆 Hinknown 9 Unknown ت 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ pendant COPD; HOCVA; CACHENA; Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed R; HYPERTENSION; CHRONIC 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 ECENTHO PNEWMONIA; ACMENTA. To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Sursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural
2 ☐ Accident 5 Pending 1 □Yes 2 □No investigation 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D65046 BACASUBRAMANIAM; 5311 old court Rd; MD 21133 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

AMBALAVANAN

82. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death July **Physician** 30 Day 200<sup>°</sup>9ª LeRoy Yellott Haile, Jr. 4:45 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Hospice Care Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 218-26-8161 February 6, 1929 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified an once. 1 ☐ Yes 2 ▼ No Director Marvland Baltimore Towson 10f. Zip Code 10e. Street and Number U.S.A. 21286 1503 Providence Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 □Yes 2 🖔 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Real Estate & Elementary/Secondary (0-12) College (1-4or 5+) Insurance Agency 0wner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rachel Lillian Stabler LeRoy Yellott Haile, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1503 Providence Road, Towson, Maryland Rena Felicity Haile / Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Hilltop Service Corp. 08-01-2009 | Towson, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Funeral Service License 21204 1050 York Road, Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) gasto intestal **Physician** untrus /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directly for esign our sequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the led by the attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day in the pest 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 ☐ Yes 2 V No 3 ☐ Probably 4 ☐ Unknown certificate has been si irector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1/ Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signarure a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NIRS 701 32. Registrar's State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 30, 2009 5:41PM Virginia A. Homan July /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Rethesda Montgomery Suburban Hospital Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Min 1 □ M 2 🛛 F September 25, 1921 Pennsylvania 87 174-16-5399 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Modical Examiner must be notified at 1 ☐Yes 2 👿 No Director Rockville Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20852 United States 10201 Grosvenor Place #1618 Funeral death permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: if Item 27 is marked other trainany injury or other trainany. 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 1 ☐ Yes 2 X No Specify: ģ 3 ☐ Widowed 4 ☑ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor Publications 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ပ Lola Bell Long George Hartwell Trude 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6230 Petunia Road Del Ray Beach, Florida 33484 Gloria Burdick/ Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State August 4, 2009 Rockville, Maryland 4 Donation 5 Dother (Specify) Parklawn Memorial Park 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase. Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licenses M00335 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PNEUMONIA Immediate Cause (Final Physician disease or condition resulting in death) ) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uniterlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) s been signed by the a 9 Unknown 23e Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an is certificate has director, page 2 s autopsy perforn 2 2 Kio 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this of funeral dire Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Aatural 5 Pending 1 ☐ Yes 2 ☐ No investigation neral Director: A 2/ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Sas, und 00052124 13110

Registrar
DHMH 17 Rev 1/2001

State

Truong Bao, M.D. 10110 Molecular Drive #206 Rockville, Maryland 20850

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

AUG 03

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 3:35 PM **Physician** August 2009 FOMIN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Age (In yrs. last birthday) Birthplace (State or Foreign Social Security Number **Funeral** Days X M 2 F 69 580-03-0587 2/19/40 **Director** St. Thomas, VI Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a State 10h County 28a-f shov 1 XYes 2 No Rockville MD Montgomery Director other traumatic event, the Medical Examiner must be notified 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 20853 4709 Iris Place USA items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc 1 Tyes 2 No
If Yes, Give 1968
Year or Dates: 1968 filed within 72 hours after 1 ☐ Never Married 2 ☐ ★ arried Saltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 XNo Specify. Specify: Black þ 3 Widowed 4 Divorced "natural". Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Self is marked other than Chemical Balance Therapist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Valdemar Hill, Sr. Florence Molyneaux 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4709 Iris Place, Rockville, MD 20853 permit. Pages 1 and 2:
Department of Health as Important: If Item 27 is any injury or other trauonce, Erica Villanova-Hill/Wife 20c. Location - City or Town, State Pages 1 ament of He 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory 8/3/09 Hanover, MD Ardent 22 Name and Address of Facility Hari P. Close F.Svs., PA 21. Signature of Funeral Service Lice 5126 Belair Rd., Balt., MD 21206-5105 Approximate Interval Between Onset and Death 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final METASTATIC NON SMALL CELL LUNG CANCER **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to intime distocause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of, death certificate be executed and burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No ate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 2 🗍 No 3 🗌 Probably 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No 1 🗌 Yes 2 🗌 No 26. Place of Death (Check only one) Physician: 25. Was case referred to medica å Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2 No 1.X Inpatient 2 ER/Outpatient 3 DOA မှ this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760, Division of Vital Records,

completely filled in by the funeral director, I or Attending P after death. Director: After the B Hospital of 24 hours a To the within 2

State Registra

DHMH 17 Rev 1/2001

29a. Certifier

one)

(check only

29b. Signature and title of certified

Medical

use of death (Item 23a) (Type, Print) 30. Name and address of person who completed PAUL 4CHANGCO S 0 31. Date filed (Month, Day,

0

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

23495

August

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

2009

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Date Month 1. Decedent's Name (First, Middle, Last) Physician 30 2000 cona Althea /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Hospice Icrest OWSON Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 18 **Funeral** Months Days Hours 231208053 1 □ M 2 🗹 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show 1 ☐ Yes 2 ☐ No Directo Himore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 Ken Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: Baltimore, Maryland 21215-0036 Black b 3 Widowed 4 □ Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) injury or other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Korvetts 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Brown P 19a Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number & Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health au
Important: If item 27 is
any injury or other trau
once. )auchter Ho. uringe 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 6 1 ☐ Burial 2 ☐ Cremation Removal from State 8-09 Baltimore MD augho C. Greene Fineral Service restern Star 8-8-09 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Baltimore National Pike 13a 1to. MO21229 5151 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 12-ARS ISCHEMIC Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 2. No 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident by the f within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certif D64395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 NOVARIES ST, SWIFE 4105 BALTIMORE, MD 21204 DANIEUE DOBERMAN, MD 32. Registrar's Signatur 31. Date filed (Month, Day, Year) State AUG 0 3 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Day 200<sup>Year</sup> 31, 5:15 p <sup>M</sup> Victor Jackson Lee 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) 7950 Gough Street Eastpoint Baltimore 8. Date of Birth (Month, Day Year) 4-9-1997 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days 217-49-1584 12 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Eastpoint 1 ☐ Yes 2X No Md. Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21224 7950 Gough Street U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) disabled disabled 5th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Victor Lee Jackson Jr. Doreen J. Patterson 19a. Informant's Name/Relationship (Type. Print) Grand-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip H. Chaney father 3711 Claremont St. Baltimore, Md. 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 8/5/2009 Parkville, MD Parkwood 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph N. Zannino Jr. F.H. 21. Signature of Funeral Service Linunsee amono 263 S. Conkling St. Balto. Md. 21224 23a. Part 1. Enter the disease, or or plica ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. I only on cause on each line. Approximate Interval Between Onset and Death 12 yrs Complications of Cerebral Palsy (343.9) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Ye ar 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

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Certification: To

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29b. Signature and title of certifier

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**Funeral** 

**Director** 

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? Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be rectified at

2 should be filed within 72 hours after a not Mental Hygiene.

Is marked other than "natural", or iter

permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any injury or other traun

Baltimore, Maryland 21215-0036

sician and burial-trans the as attending nse the detached peen ( director, this funeral Hospital or Attending Pl 24 hours after death. Funeral Director: After t After

law requires that the death certificate be executed

Box 68760.

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Division of Vital Records,

Im edial Cause (Final di eas r condition sulling in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chromosone 10q, deletion(758.33) 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy ormed? 2 🛂 No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 APesidence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Catherine Parrish M.D.

1501 S. Clinton St. Baltimore, Maryland 21224

29d. Date signed (Month, Day, Year)

8-3-2009

29c. License number

D 33167

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2009 Month August 1, 5:11 A.M Pauline Hershberger Jones 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Carroll 2025 Cape Horn Road Hampstead 8. Date of Birth (Month, Day, Ye Sep. 7, 1 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 1 □ M 2**X**XF Months Days Hours Min. West Virginia 92 Yrs. 236-24-1407 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 X No Maryland Carroll Hampstead 10g, Citizen of What Country? United States 10e. Street and Number 10f. Zip Code 21074 2025 Cape Horn Road of America Was Decedent Ever in U.S. Armed Forces? 1 Yes No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes XXNo Specify: Specify: XXWidowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Roper Products College (1-4or 5+) Elementary/Secondary (0-12) Manufacturing Company 8th Machine Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Kester Hershberger Edna Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary Paulette Manion (Daughter) 2025 Cape Horn Road, Hampstead, Maryland 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) Aug. Date 7 20c. Location - City or Town, State 20a. Method of Disposition 1XX urial 2 Cremation 3 Removal from State 2009 Looneyville, WV Ferrell Cemetery 4 □ Donation 5 □ Other (Specify) Signature of Fundral Service Licensee Eckhardt Funeral Chapel, P.A. Kmain 3296 Charmil Drive, Manchester, Maryland 21102 d. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner

The law requires that the death certificate be executed

Box 68760.

P.O.

Division or Vital Records,

Physician

/Medical

**Examiner** 

10a. State

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shown any injury or other traumatic event, the Medical Everal once.

burial-transit the Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica stely filled in by the funeral director, p.

Examiner Physician/Medical Be Completed by Medical Certification: To

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Lines underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. autopsy performed? Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only

within 24 hours at To the Funeral D completely filled i

29b. Signature and title of certifi

30. Name and address of person who Impleted cause of death (Item 23a) (Type, Print) Northwoods Trail Hampstead MD01014 4231

Registrar

and manner stated

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** William July 28 2009 9:30p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Hospital Center Carrol1 Westminster If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 1 M 2 □ F 218-05-7388 89 **Director** March 31 1920 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show Department of Health and Mental Hygiene. Important: or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be motified at MD Carroll Sykesville 1 ☐ Yes 2 X No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6108 Oakland Mills Road 21784 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No WW] If Wes, Give Year or Dates: 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes 2 ☑ No Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Army Corporal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George William Karl Mary Kochanski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Adele Karl (spouse) 6108 Oakland Mills Rd., Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial 8-3-09 Sykesville, MD 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Dugestright Sterberst P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARTERIOSCIBROTIC CARNOSASWUR **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed ending physician and use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending properties for use as IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Year 5 Other (specify) been signed by the should be detached ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Whiknown Completed within 24 hours after death.

To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖃 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 2 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainter as stated. 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State 31. Date filed (Month Day Year) Registrar

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Amend #3 per MD 8894 873 Department of Health and Mental Hygiene

				State of Ma	•	Certificate of			eg. No. 0 0 9	24668
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3	Funeral Director		214-01-0923  Usuel Residence of Decedent	_M 2X) F	90 Y	Months Devs		8. Date of Birth (Month, Dey. 12-06-1	918 MAI	rthplace (State or Foreign ountry) RYLAND
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	or 28	ě	10e. Street end Number			10f. Zip Code		1	0g. Citizen of Whet C	ountry?
	23e	la l	12306 TIMBER GROVE			2111			USA	
Maryland 21215-0020	s 1 and 2 should be filed within 72 hours efter death with the Maryland if Health end Mental Hygiene. Item 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event, the Medical Examiner marker recitling at	by Funeral Director	11. Marital Status  1 □ Never Merried 2 □ Married  3 🌣 Widowed 4 □ Divorced	12. Wes Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Detes:		13. Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 ☐ No		ecity Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
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Baltimore,	permit. Peges 1 and Department of Health Important: If Item 27 any injury or other ti DNCE.		21. Signature of Puneral Service Licens		11	22. Name and Addi	ress of Facility SOL	LEVINS	ON & BROS. IKESVILLE,	, INC.
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	To the Hospital or Attending Ph within 24 hours efter deeth. To the Funeral Director: After th completely filled in by the funeral	M	29b. Signature and title of certifier			29c. Licer	nse number	2	29d. Date signed (Mor	nth, Day, Yeer)
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			30. Name end address of person who co	ompleted cause of de	eth (ttem 23e) (T	ype, Print)	-		1	
			Raymona Millie Z	5 Main &	Torest.	Soute 2000	Rustostown	MD Z	1136	
	Sta Registr	- 52	31. Date filed (Month, Day, Year)  AUG 0 3 200	9 32 Registra	r's Signeture	29c. Licer Di ype, Print) Sure 200				

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ician dical	1. Decedent's Name (First, Middle, Last)  Bertie	H. Kenr	nedy	2. Date of De. Month	Day Year	3. Time of Death  4 OP N
niner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of E	Death	4c. County of Death	
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Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Cou	ntry?
a Di	5707 Daybreak Terrace		21206		USA	
Funeral	11. Marital Status  1 □ Never Married 2 □ Married  12. Was Decedent Ever in Armed Forces?  1 □ Yes 2 ☑ No	n U.S. 13. V	Vas Decedent of Hispanic Origin f Yes, specify Cuban, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)	14. Race - Ameri Black, White,	
by	3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3 Notice 3		I□Yes 2XXINo Specify:			nite
lete	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupation kind of work done during most o OO NOT use retired)	f working	16b. Kind of Business/Ir	ndustry
Completed	Elementary/Secondary (0-12) College (1-4or 5+)  8th		pector		AT & T	
Be C	17. Father's Name (First, Middle, Last)		18. Mother's	Name (First, Middle,	, Maiden Surname)	
ToE	James A. Hodge		Mag	gie Rai	nes	
	19a. Informant's Name/Relationship (Type. Print) Marie Morris / daughter		g Address (Street and Number of 1 Hazelwood		er, City or Town, State, Zi Baltimore	
		b. Place of Dispos	sition (Name of	Date	20c. Location - City or T	
	147 Ruriat 2 Cramation 3 DRamoval from State	cemetery, cren	natory or other place)	7/23/09	Rossville	
	21. Signatur of Funeral Service Licensee	22	. Name and Address of Facility	300 Mac	e Ave. Bal	to. MD
	23a. Part1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line.	7.	Connelly Fu	neral Ho	me of Esse	
al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitution of the constitutio	sequence of). nent	Pertens.a	эn		
hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3 □	Ectopic pregnancy Other (specify)		23d. Date of deliv	very Day Year
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일		2 ER/Outpatien		ing Home 5□ Resi	idence 6 □Other (Spec	ify)
ion:	27. Manner of Death  15 Natural  5 Pending  (Month, Day Year	r) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		how injury occurred	
Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - A building, etc. (Sp	At home, farm, streecify)			Street and Number or Rui wn, State)	ral Route Number,
<u>a</u>	29a. Certifier  (Check only (Check only 2   Medical Examiner: On the basis of exam	knowledge, death	n occurred at the time, date and	place, and due to the	cause(s) and manner as	stated.
	one) and manner stated.	mination and/or in				
edical			29c. License number		29d. Date signed (Month	
	29b. Signature and title of certifier	0	H00544	129	7-20-	09
edical	30. Name and address of person who completed cause of death (  Cyrus Asadi, 606 Hammond  31. Date filed (Month, Day, Year)  AIG 03 2009  AIG 03 2009		HOO544 HLZ Block	124 17n, MI	7-20-	09

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Carroll W. LeBrun Sr. 07 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Franklin Square Baltimore Kosedale 8. Date of Birth (Month, Day, June 19, Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F 84 Maryland Director 219 18 3758 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Inportant: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, It. Modical Examination to continue the could not once. Middle River 1 ☐ Yes 2 No Maryland Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21220 USA 3747 Clarks Point Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☑Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 1 □Yes 2 No Specify. þ 3 ☐ Widowed 4 N Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Steel Mill Crane Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Wenker John Carroll LeBrun 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21634 2716 Hoopers Island Rd. P.O. Box 213 Fishing Creek, MD. Elaine Marie Airey (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gardens 8/5/2009 Baltimore, Maryland 4 Donation 5 Dother (Specify) 21. Sign dure of Funeral Service Lie 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examine Hospital or Attending Physician: he law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 22 00 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation n 24 hours after death.

Re Funeral Director: Aft bletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D39758 7-31-2009 K. Y. Schuder 9114 Philadelphia RD, Suite 300 BACTO MD 21237 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Kevin Schendel MD

3

2009

31. Date filed (Month, Day, Year)

AUG 0

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 246 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3, Time of Death Day Year **Physician** 1:00PM M 31, 2009 July Samouil Lelchitski /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a, Facility Name (If not institution, give street and number) Examiner Montgomery Suburban Hospital Bethesda If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 X M 2 □ F Yrs 87 December 23, 1921 Ukraine Director 249-95-6800 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show Department of Health and Mental Hygiene. Important; or items 23a or 28a-f show important; if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventine Trust be notified at once. 1 X Yes 2 No Director Rockville Maryland Montgomery 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 12630 Veirs Mill Road #1606 20853 United States Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: à 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 5+ Manager Sports 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Sophia Gochfeld <u>Boris Lelchitski</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 351 Booth Street Gaithersburg, Maryland 20878 Boris Lelchitski/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 2, 2009 Rockville, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Fu And Service Licenses M00335 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death rterioscleratio Cardiovaswlar Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner elshitski, Samon attending physician and for use as the burial-tran Due to (or as a consequence of) of Vital Records, P.O. Box 68760, IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 □ Yes 2 □ No Day Pregnant at time of death 5 ☐ Other (specify) 9 DUnknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 No 1 ☐Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only on Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural ∠ Accident 5 ☐ Pending investigation within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only and manner stated. 29b. Signature and title of certifler 29d. Date signed (Month, Day, Year) 09 address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Geometrus Rel 30. Name and Registrar's Signature 31. Date filed (Month, Day, Year) State 0

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM#20b, c, perFH, G894, 8/14/09, WS

			For State Registrar	State of Ma	-	epartment of t Certificate of			giene Reg. No.	00	on the second to
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	/Medic Examin		4a. Facility Name (If not institution, give				r Location of Death		4c. County	of Death	
	Funeral Director		Shady Grove Adventily Shady Grove Adventily Shady	e (In yrs. last birt	Rockv hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da August 1,	th	9. Birthp Coun Ch	ery blace (State or Foreign nina	
Maryland	-f show	tor	Usual Residence of Decedent	nerv	10c. City, Town	or Location thersburg				11	0d. Inside City Limits 1 ∐Yes 2 🕅 No
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<b>036</b> ours after deat	n and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Evar. The Figure be notified at	by	11. Marital Status  1 □ Never Married 2 🕅 Married  3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1  Yes 2 N If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cub 1 □ Yes 2X No		pecify Yes or No Rican, etc.)	14. Rac Blac Specify	e - Americ ck, White, e	
1215-0 /ithin 72 bo	ne. han "natul Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5-		Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of world	king	16b. Kind of Bi		· ·
Baltimore, Maryland 21215-0036	tental Hygie ked other t ic event, th	To Be Co	17. Father's Name (First, Middle, Last) Renging Li			Accoun	18. Mother's Nam				
, Mary and 2 shou	Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.	23	19a. Informant's Name/Relationship ( Sherry Wei/Gra		: 1	Mailing Address (Street 7802 Calaba	r Drive,	Gaither	sburg, l	Mary1	and 20877
timore	tment of Hart: If iten		20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	ý)	20b. Place of cemeter Park I	Disposition (Name of y, crematory or other pla awn Memoria	Girran	· }	20c. Location - Rockvill	le, M	aryland
Bal	Depar Impor any in once.		21. Signature of Funeral Service Licer		101544	Robert A. 300 West M	ess of Facility Pumphrey Iontgomery	Funeral Avenue	Home/Rockvi	ockvi Lle,Ma	lle, Inc. ryland 20850
1	nysician and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ither privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege and ithe privilege an	edical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	one cause on each ling a.  Pneumo Due to (or as a Due to (or as a Due to (or as a Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Contro	ne. Onia a consequence d Agia a consequence d	of): of):	ing, such as cardiac	or respiratory a	irrest,		Approximate Interval Between Onset and Death
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DIVIS	urs after de ral Directo lled in by th	Certification:	3 Suicide 6 Could not be determined	building, etc	c. (Specify)	rm, street, factory, office		City or To	wn, State)		al Route Number,
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\$ 02	within To th	Me	29b. Signature and title of certifier  halane	. Rane	'MD		se number 68178		29d. Date signe		Day, Year) - 2009
			30. Name and address of person who Santosh Rane, M.1	completed cause of d D., 9901 M	eath (Item 23a) (	(Type, Print) Center Driv	e, Rockvi	11e, Ma:	ryland 2	20850	
	Sta Registr		31. Date filed (Month, Day, Year)		ar's Signature						
DUIN	L47 Day 4/2	004	AUG 0 3 2009	Senera	D. 19	ark					

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	- 10.10	nent of Health and Mental Hi cate of Death	reg. No. 200	9 2467
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) Craig Gregory Lewtas		2. Date of Death Month Day Year July 28, 2009	3. Time of Death 1627 hrs
······································	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Deat	
)	2519 Vineyard Lane  5. Social Security Number   6. Sex   7. Age (In yrs. last b)	irthday) If Under 1 Year If Under 24Hrs	Anne Arunde  8. Date of Birth(MM/DD/YYYY) 9. Bi	
Funeral Director	217-19-0495 XXM 2_F 38	Yrs. Months Days Hours Min	Forei	gn puntry)England
Maryland 28a-f show any d at once.	Usual Residence of Decedent           10a. State         10b. County         10c. City, Tow           MD         Anne Arunde1         Crofto			10d. Inside City Limits  1 Yes 2XX No
the Maryland a or 28a-f sh tified at onc	10e. Street and Number 2519 Vineyard Lane	10f. Zip Code 21114	10g. Citizen of What Cou	untry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	11. Marital Status  Never Married  2XX Married  12. Was Decedent Ever in U.S.  Armed Forces?  1 Yes XX No	13. Was Decedent of Hispanic Origin? ( Si If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- 14. Race - Ame	rican Indian, Black,
rs after or ural", o	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 162	1 Yes XX No specify:  a. Decedent's Usual Occupation (Give kind of v	specify: Whi	
5-0036 ed within 72 hour lygiene. he Medical Exar	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use reti	red)	,
within siene.	11 17, Father's Name (First, Middle, Last)	Tow Truck Operator	Towing (First, Middle, Maiden Surname)	
215- be filed that Hyg rked off cnt, the	Leslie Lewtas	i	a Christina May	
D 21; should be nd Men is mar To I		9b. Mailing Address (Street and Number or I 2519 Vineyard Lane C		e, Zip Code)
e, MI and 2: and 2: Tealth a item 27 traum	20a. Method of Disposition 20b. Place	e of Disposition (Name of cemetery,	Date 20c. Location - City o	r Town, State
MOFe Pages 1 ent of 1 int: If	I Bullat 2 K Notellation 3   Removaliton State	atory or other place) antic Crematory 8/5	/2009 Glen Burn	ie, MD
Salti ermit. Departm mporta njury o	21. Signature of Functial Survice Licensee	22. Name and Address of Facility Six Services, PA. 1 2nd		
Physician	23d. Part- Enter the disease or complications that caused the death. Do			Approximate Interval Between Onset and
/Medical Examiner	failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Multiple blunt Due to (or as a consequence of):	force injuries		Death
-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
ted histi	Course Enter Underlying Course (Disease or injury that initiated	- <u></u>		
executed an and all - transit	d d	WE COOK 9/26/	<del>^</del>	
	23a,27,28	ced per ME G894 8/26/ 8a-f,permE, g896 10/2	20/09 TT	
ox 6876 ant certifica attending ph or use as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown 2 Unknown 2 Unknown	2 Fetal death 3 Ectopic pregnate 5 Other (Specify)	ancy 23d. Date of delive	ry Day Year
p.O. Bothat the dedected by the by Phy	Part II. Other significant conditions contributing to death but not result	ing in the underlying cause given in Part I.	23e. Did tobacco use contribute to	
S, P.(			1 Yes 2 No 3 Pro	
of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by funeral director, page 2 should be detach in: To Be Completed by P.				
ician: s certifi rector, I	25. Was case referred to medical examiner? Hospital: 1 Innation: 2 FP/	26. Place of Death (Check Outpatient 3 DOA Other, Nursin		or: Seana
of Vigenthismeral di	1 Yes 2 No	D. Time of Injury	28d Describe how injury occurred subject fell from	
Sion Attendin death. ctor: A by the fu	Natural 5 Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pending Pend	1616 hrs 1 Yes 2 X No	window	
♦ Division of ¹ To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral edical Certification: T	4 Homicide determined (Specify) residence	farm, street, factory, office building, etc.	28f. Location (Street and Number or R or Town, State) 2519 Vin Crofton, MD	Rural Route Number, City eyard lane
To the Hospital within 24 hours to the Function to the Function completely filled	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/o and manner stated.	r investigation, in my opinion, death occurred	at the time, date and place, and due to t	the cause(s)
2	29b. Signature and title of certifier  MM  M  T	29c. License number O.C.M.E.	July 29, 2009	опп, рау, чеаг)
	30. Name and address of person who completed cause of death (Item 23a Russell Alexander MD. Assistant Medical Examine		D 21201	
State Registrar	31. Date filed (Month, Day, Year) 32. Jegistrar's Signature	harl		
DHMH 17 Rev 1/2001	nuo v	PRIGINAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year July 2009 **Physician** Verna С. Miller 31, 5:25 P M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Gilchrist Towson Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours 11/14/1917 Months 1 □ M 2**X** Maryland 215-09-2820 91 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, I'm Medical Examinations to a colling of 1 ☐ Yes 2 X No Director MD Baltimore Towson 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 409 Virginia Ave. # 221 21286 USA Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after an nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or iten 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hutzler's Retail 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George G. Miller Theresa E. Goldbeck ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau Frank G. Lidinsky / Nephew 8600 LaSalle Road Suite 320 Baltimore, MD 21286 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer 8/8/2009 Baltimore, Maryland 22. Name and Address of Facility Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York of Funeral Service Licensee Ruck Towson Funeral Home, Inc.

23a. Part 1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. Road Immediate Cause (Final intestina nknown Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duete (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day in the past 12 months?

1 Yes 2 No
9 Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐No 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation 24 hours after death.

e Funeral Director: Aft 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hor To the Fune completely fi (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31 Date filed (Month, Day,

03

DHMH 17 Rev 1/2001

darlane Columbia

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 24675 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** Morris 10:41AM 2009 39 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Balhmore Baltimore If Under 1 Year | If Under 24 Hrs. / Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 08-13-CHARLE **Funeral** Months Days Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Medical Exercines must be notified at 1 Yes 2 No Director Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2120 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 ☐No þ Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) General 1 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) onnie Kooker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2825 Mohawk Ave Baltimore, MD 21207 wife altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State Battimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Hoe My 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis **Physician** Days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner neumonia Days Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit and be exect Due to (or as a consequence of): attending physician Box 68760 Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 호 in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) P.0. the 9 Unknown signed by the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an cate has page 2 s autopsy certificate 1 ☐ Yes 2 🗷 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 5 ☐ Pending investigation 1 Natural n 24 hours after death.

le Funeral Director: Aft
bletely filled in by the fur 1 □Yes 2 □No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 000 July 29, 2009 K. Kusuma MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KANAPARTHI MD Sinai 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

MCCRAY

DHMH 17 Rev 1/2001

State

Registrar

31. Date-filed (Month, Day, Year)

AUG 0 3 2009

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year PAULINE K. PAPAROUNIS 28 Jul 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death MANORCARE RUXTON TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) JULY 31,1923 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 🗆 M 212-28-1567 85 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 603 S. ANN STREET APT 213 21231 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 □ Yes 2 □ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No WHITE Specify. Specify: 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 3RD College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) NICHOLAS G. PAVLAKOS ESTELLE THOMAKOS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BILL PAPAROUNIS-SON 10129 FONTAINE DRIVE PARKVILLE, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State PARKWOOD CEMETERY 7/31/09 BALTIMORE, MD 5 ☐ Other (Specify) 4 ☐ Donation 21. Sign tore of 22. Name and Address of Facility CHARLES S. ZEILER AND SON, INC al Service Licensee un 6224 EASTERN AVE BALTIMORE, MD 21224 Part 1: shock Enter 'e tisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or he art f-ilure. List only one cause on each line. Approximate Interval Between Onset and Death Imme Cause (Fin-I - NNO Week Due to (or as a sequence of) Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9☐Unknown

Physician /Medical **Examiner** 

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funeral

After

after death.

I Director: /
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within 24 hours aft To the Funeral Di completely filled ir

Medical

The law requires that the death certificate be executed

or Attending Physician:

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Division or Vital Records, P.O. Box 68760,

**Physician** 

/Medical

**Examiner** 

10a. State

MD

Funeral

**Director** 

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Important: If ite
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Director

Funeral

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Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Examine Physician/Medical Completed Be ို

Certification:

resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or hijury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Peath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Natural Accident 5 Pending investigation 1 Yes 6 Could not be 3∏ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[ Medical Examiner: On the basis of examination and/or investigation in my actions and the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

31. Date filed (Month

29c. License number

29d. Date signed (Month, Day, Year)

3 ☐ Probably 4 ☐ Unknown

30. Name and ac

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 4:250 M Hazel Lillian Parker 30 UL 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL SINAI BAUTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Hours New York Days 1□M 21 F Months 073-38-6987 93 9-10-191 Director Usual Residence of Decedent 10c. City, Town or Location the Maryland 10b. County 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar mast be notified at 1 ☐ Yes 2 No Director Pikesville Baltimore Co. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21208-2808 4007 Old Court Road USA Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2 should be filed within 72 hours after or and Mental Hygiene.
is marked other than "natural", or ite 1 Never Married 2 Married 1 ☐ Yes 2 🕍 No Baltimore, Maryland 21215-0036 Specify Specify: White þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) N/A Elementary/Secondary (0-12) 12 Home Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Merrell (unk) Houghton ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traun once. NY,NY 10024 <u> Granville Parker - Son</u> <u>West 85th Street Apt 1</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 7-31-09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Lice 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE RESPIRATORY **Physician** DAY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner POXEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has heen sinned by the manual control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the con PNEUMONIA ASPIRATION burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, 0945 NTRACRANIAL HEMMORILHAGE Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 DUnknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? Yes 200 No 1 Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only on Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Nipatient 2 ER/Outpatient 3 DOA Certification: To funeral ( 27. Manne of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a
To the Funeral D

State Registrar

DHMH 17 Rev 1/2001

PARKER

31. Date filed (Month, Day, Year) 03

29a. Certifier

(Check only one)

29b. Signature and title of Pertifier

RAVITEJ

WEST BELVEDERE AVE 2. Registrar's Signature

2401

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1CH WICHUN

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician  $P^{M}$ Bertha Roros July 2009 31 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Riverview Rehab. & Health Cen Paltimore
9. Birthplace (State or Foreign
Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 ☐ M 2 🔀 F Months Davs 95 197-20-8299 2-11-1914 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I'm Modical Event from that by the United at Baltimore Essex 1 ☐ Yes 2 No Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1 Eastern Boulevard U.S.A. 21221 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo þ Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie Ogrenchig Theodore ပ Divic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sophia Avgerinos - Niece 7420 Poplar Avenue Baltimore, Md. 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or otl 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 8-3-2009 | Baltimore, Maryland Oaklawn Cemetery: 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Joseph N. Zannino Jr. F.H. 21224 263 S. Conkling St. Baltimore, Md. 23a. Part 1. Enter the dileas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart filture. List only one cause on each line.

Immediate Cause (Final disease or condition) Approximate Interval Between Onset and Death 1 — 2 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): requires that the death certificate be executed and burial-trar resulting in death) Last Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) P.0. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 V No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After the funeral 28a. Date of Injury (Month, Day, Year) 27. Manuer of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated

State Registrar

within 2

29b. Signature and title of certifier

MALIKA

M-D

WASERM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

709.

BASTERN BLUD,

29d. Date signed (Month, Day, Year)

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	Registrar  1. Decedent's Name (First, Middle, Last)						ertificate of Death				th	UUZ	3. Time of Death	
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/Medic Examin								Location of Dea				unty of Death		_
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and		Usual Residence of Decedent  10a. State 10b. County	1	10c. City,	Town or Loc	cation							10d. Inside City Limits	-
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r 28a	Director	10e. Street and Number				10f. Zij	Code			1	0g. Citizen	of What Co	untry?	_
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ems;	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	er in U.S.	. 13. V	Was Dece f Yes, spe	dent of His	spanic Origin? n, Mexican, Pue	(Specify	Yes or No-	14.	Race - Ame Black, White		
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ie, wan y latter 2.12.13-0030  I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygene.  If Health and Mental Hygene.  other traumatic event, the Medical Evaning rust be notified at		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number of							or Rural Route Number, City or Town, State, Zip Code)					
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permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service Licen	966		I .							Funeral Home		
		3620 Wilkens Ave., Baltimore, MD 21229  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate											Approximate	-
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tal or safte	Certification:	4 Homicide building, etc. (Specify)								3.9 5. 75, 5.6)				
To the Hospital or Attending Physician: The law requires that the death certification 24 fours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical													
the h	Medi	20c License number 29d Date signed (Month Day Year)												
<b>6</b> ≱ <b>6</b> ⊗	9-200 Signature and title of certainer of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of th									46H27 07/28/2009				
		30. Name and address of person who												_
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Sta	te	31. Date filed (Month, Day, Year)	32. Registrar	's Signatu	ire &	60.0		- F	- 7 1	-				_
Registr	ar	AUG 0.3.2	WIND MELLEN	4	19. 14	Marin Contract								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** July 2009 11:53P M Reese Margaret Louise /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Glade Valley Nursing & Rehab. Ctr. Walkersville 8. Date of Birth (Month, Day, Yeer)
Jun. 20, 1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 🔀 F 1925 84 Director 216-22-9837 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 ☐ No Funeral Director Frederick Walkersville Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 56 W. Frederick St. 21793 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify. Specify: Completed by White 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grede completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Lest) Be ပ E. Earl Stultz Florence Rebecca Baile 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dorothy Frock/ daughter P.O. Box 274 Littlestown, PA 17340 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If its any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Linganore Cemetery 7/31/2009 Unionville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Hartzler Funeral Home athanise ( Union Bridge, MD 21791 6 E. Broadway 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each inc. Approximate Interval Between Diset end Death Immediate Cause (Final **Physician** disease or condition resulting in death) umm /Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a cops or Attending Physician: The law requires that the death certificate be executed after death. physician and s the burial-tran Box 68760,% Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Š 3 Probably 4 Unknown 1 ☐ Yes Completed Were eutopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performe certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To 28a. Date of Injury (Month, Day, Year) To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 2 Accident 1 ☐ Yes 2 🗌 No 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) 32. Registrar's signature State Registrar

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Patricia Marie Ryar	1- P	For State		larylariu 			of De		an i C				g. No.	20	3 9 24 6 8
Physician/ Medical Examine	4	1. Decedent's Name (First, Middle,Last)  Month								Day	Year	1254 hrs			
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Funeral	5	5. Social Security Number	6. Sex	7. A	ge (In yrs. Ias	t birthday	~ <del>     </del>	Under 1 Y	Year Days	If Under Hours	24Hrs. Min.			Foreig	rthplace (State or
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any	_	Usual Residence of Decedent 10a. State 10b. County			10c. City, T	own or L	ocation								10d. Inside City Limits
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the Maryland a or 28a-f sh lifted at once	<u> </u>	10e. Street and Number			<u> </u>		101	f. Zip Cod	ie			1	0g. Ci	tizen of What Cou	untry?
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ms 23		11. Marital Status		Was Deceder Armed Forces		. 13	B. Was De	ecedent of specify Cu	f Hispa Jban, I	anic Origi Mexican,	n? ( <b>Sp</b> e Puerto R	cify Yes or No lican, etc.)	)-	14. Race - Ame White, etc.	rican Indian, Black,
r death	Funeral	1 Never Married 2 N	1	Yes	2 X No		1 Yes	. 2 🕶	No	specify:				Specify:	White
s after ural", miner	2	Widowed 4 X Di 15. Decedent's Education (Sp.	vorced If Ye or D	ates:	ompleted)	16a. Dec	edent's U	Isual Occ	upatio	n (Give k	ind of wo	rk done	16b.	Kind of Business	
2 hour	ᇎ	Elementary/Secondary (0-12		College (1-4 o		duri	ing most o	of working	; life. [	DO NOT L	use retire	ed)			
036 thin 7 ne.	Completed	12		2			techi	nica]	L w	rite	r	First, Middle,	Maida	comput	er
15-0 iled w Hygie fothe		17. Father's Name (First, Middle							18					berger	
21215-0036 Muld be filed within 7 Wantal Hygiers marked other than ic event, the Medica	음 일	Merl J. Ryan  19a. Informant's Name/Relation	ship (Type,	Print) mo	ther	19b. N	Mailing Ad	Idress (S	Street	and Num	ber or Ru	ural Route Nu	mber,	City or Town, Sta	te, Zip Code)
MD 2  nd 2 shou alth and N  n 27 is n	-	Shirley M. Her			an-	91	88_O	ak Tı	ree	Ct.	F		ck,	MD 2170	)1
e, N 1 and 1 Health item	Ì	20a. Method of Disposition			20b. P	lace of D	or other I	n (Name o	of cem	etery,		Date	200	c. Location - City of	or Town, State
MOFE Pages 1 Pent of H ant: If it	-	1 Burial 2 XCrematic		emovai irom		Cou	nty (	Crema						Sykesvil	
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death wi Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner must be a considered by Europe	t	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hartzler Funeral F													
	$\perp$	(attarine	(V.)	and that of	od the death	Do not e	118	02 L	ibe	rty such as ca	Rd. ardiac or	Liber respiratory ar	<u>tyt</u> rrest, s	hock, or heart	Approximate interval
Physician 'Medical		failure. List only one cause on each line.  Multiple Injuries											Between Onset and Death		
aminer.	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):														
		Sequentially list conditions, b.													
1	Ē.	if any, leading to immediate cause. Enter Underlying Caus	e c	to (or as a co	nsequence of	):									
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executian and ial - tra	lical	UNPENDED		MENDED											
Box 68760, e death certificate be exe the attending physician a certificate active as the burial -	sician/Medica	IF FEMALE:		3c. If yes, out		nancy			0	Fatani	c pregna	nov		23d. Date of delive Month	very Day Year
687 certifi nding	ian	23b. Was decedent pregnant in past 12 months?	1	Live birth Pregnan	n tattime of de	ath 5	==	death r (Spec <i>if</i> y	3 [	Ectobi	c pregna	ПСУ		Month.	,
Box le death the attered for u	ysic	1 Yes 2 No 9 🗸 l	,	-											I doub?
O. I at the d by the ctached	y Phy	Part II. Other significant con-	ditions co	ntributing to d	eath but not re	esulting i	in the und	derlying ca	euse g	given in Pa	art I.				to the cause of death?  Probably 4 Unknown
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the rs after death.  The Director: After this certificate has been signed by it is the funeral director, page 2 should be detached in by the funeral director, page 2 should be detached.	ed by	() <del></del>										24a. Wa	_	Strong-Service	autopsy findings available
cords, law requir has been s	Completed											aut	topsy rforme		
Reco	mo;											1 🗸 Yes			Yes 2 No
Vital Rec ysician: The l	Be C	25. Was case referred to med examiner?		oital:		ED/0-4			_	of Death Other		only one)	Res	sidence 6 🗸 O	ther: Scene
of Vit ing Physic After this	ဥ	1 ✓ Yes 2 No 27. Manner of Death	1130,	28a. Date of	atient 2		patient :			ry at Wor		28d. Describ	e how	injury occurred	
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isio	icat		vestigation ould not be	28e. Place	of Injury - At h	ome, far	m, street,	factory, c	office b	ouilding, e	etc.	or Town	State	<u>a)</u>	Rural Route Number, City
Div ital or urs aft	Certification:	4 Homicide	etermined	To the second	Local Stre							10506 Libe	rty Ro	oad, Frederick ,	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exe within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician a completely filled in by the funeral director, page 2 should be detached for use as the burial		29a. Certifier (Check only one) Certifying Medical E	Physician: xaminer:0	To the best of	of my knowled examination a	lge, deat and/or in	th occurre vestigatio	ed at the ti on, in my c	ime, d opinior	ate and p n, death o	ccurred	d due to the ca at the time, da	ause(s ate and	and manner as diplace, and due t	stated. to the cause(s)
To t vith To com	Medical	29b. Signature and title of cer	ar	d manner sta	ted.					se numbe					(Month, Day, Year)
		Morrise	The	96,	10				O.C.	M.E.				July 26, 2009	
4		30. Name and address of pen					111 Pe	nn Stro	et P	Saltimor	e. MD	21201			
		Margarita Korell MD		stant Medi	istrar's Signar		iiire		, L		5,				
St Regist	ate trai	6 2 2 2 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	3 2009	Ben	m,	8.	par	Les!	_						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 4 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009 Year July 30°, **Physician** Rice, Sr. 1:00P M Albert J. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Tate House Linthicum If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Sept. 9, Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min. Months Days Hours 1 X M 2 □ F 84 T924 Maryland 218-14-0043 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b County 10c. City. Town or Location 77 is marked other than "natural", or items 23a or 28a-f show traumatic event, the We down Examine in ust be notified at 1 ☐ Yes XX No Director MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 253 Glen Gary Garth 21061 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes XX No 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: White If Yes, Give Year or Dates Specify ۵ XX Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) t of Health and Mental Hygiene. If item 27 is marked other than Machinest Ship Building 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rice Helen ပ Harry Murphy 19a. Informant's Name/Relationship (Type. Print) / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Brenda A. Stewart 253 Glen Gary Garth Glen Burnie, MD 21061 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department or Important: If i any Injury or once. ö XXBurial 2 Cremation 3 Removal from State Meadowridge Mem. Park 8/5/2009 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signatur of Funes 15 Services, PA. 1 2nd Ave SW Glen Burnie, MD 21061 Mazzo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760. IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year ☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy 1 ☐ Yes 2 ☑ No : After this certifical funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 2 🗷 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A investigation 2 Accident the 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and litte of certifier eath (Item 23a) (Type, Print) 30. Name and address of person who completed cause of MO 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 5:30 A JULY 31. 2009 SCHUESSLER FRANCES /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE PARKTON 1506 RAYVILLE ROAD 8. Date of Birth (Month, Day, Year) 10/31/1928 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🖸 F MARYLAND 219-22-8689 80 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f shov Examinar must be notified at 1 ☐ Yes 2 ☐ XNo Director BALTIMORE PARKVILLE MD within 72 hours after death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 USA 3001 PUTTY HILL AVENUE Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Completed by WHITE 3 Widowed 4 □ Divorced "natural", 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) OWN HOME 12TH GRADE HOMEMAKER 2 should be filed w and Mental Hygie is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be REGINA SEARS ပ္ JOHN KONSKI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 sment of Health an 1506 RAYVILLE ROAD PARKTON, MD 21120 LYNN KRUFT/DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition permit. Pages 'Department of H Important: If Ite any Injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State METRO CREMATORY, INC. 8/4/2009 CATONSVILLE 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee MO1139 TOWSON, MD 21286 teatu 8521 LOCH RAVEN BLVD. Pott 1. Enter the disease, or con plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LUNG CANCER **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-trans Due to (or as a consequence of): Box 68760 death certificate be Physician/Medical attending p as IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day 5 Other (specify) P.0. the detached 9 Unknow signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Was an autopsy performed page 2 s has certificate 1 ☐ Yes 2 Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one, DAUGHTER'S RESIDENCE Other: 4 Nursing Home 5 Residence Hospital: No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes ၉ funeral 27. Manner of Doath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: I or Attending Fafter death. After (Month, Day, Year) Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ 4 ☐ Homicide filled in within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

GARY COKEN, MD

AUG 0 3 2969

6ARY COHEN MP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

1 cause of death (Item 23a) (Type, Print)
6/69 N. WARIED ST. BATTIMENE, MD 2/20

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Date c. Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Ve ar **Physician** dela cle 7.000 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** hospital Northwest Randalls town Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, **Funeral** Hours Year) Months Days 1 □ M 2 🔽 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla pepartment of Health and Mental Hyglene. In Pepartment of Health and Mental Hyglene Inductant: It item 27s a marked other than "natural" or items 23a or 28a-f show Important: It item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Exterior or at Learn Miles at 1 Nes 2 No Director nore timole 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2120 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc 1 ∐Yes 2 ↓ If Yes, Give Year or Dates: 1 ☐ Neyer Married 2 ☐ Married 2 No 3altimore, Maryland 21215-0036 1 □ Yes 2 🕠 🗥 0 a 2 Specify: 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jamaica 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Doppation 5 □ Other (Specify) 21. Sign rule of Funeral Service Licensee 21207 MU 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mila **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, living cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a consequence of and Due to (or as a consequence of) Box 68760, ned by the attending physician detached for use as the buria Physician/Medical the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 Do P.0. 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 4 Unknown 1 🗌 Yes 2 🗌 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an certificate has autopsy performed 2 🔲 N 1 🗆 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 27. Manner eath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 atural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature eg title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

Registrar DHMH 17 Rev 1/2001

State

LOUY ROCK

Old

Ranchillstown

d address of person who completed cause of death (Item 23a) (Type, Print)

5401

32. Registrar's Signatu

10gib.

31. Date filed (Month, Day, Year)

AUG 0 3 2009

AUG

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death  $J_{uly}^{\text{Month}}$ <sup>□</sup>2009 **Physician** 29, 5:53 A M James K. Shafer /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months 1**X** M 2□ F 577-54-0679 95 1914 Nebraska **Director** June 1, Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show r 28a-f shov 1 ☐ Yes 2X No Directo Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or ury or other traumatic event, the "Medical Examine". As the 20817 United States 6913 Marbury Road 12. Was Decedent Ever in U.S. Armed Forces? 1 1 1 1 2 1 No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🕅 No þ Specify: Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States College (1-4or 5+) 5+ Elementary/Secondary (0-12) Physician Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bertha Koken Michael Charles Shafer ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie J. Nelson/Daughter 6913 Marbury Road, Bethesda, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1
Department of F
Important: If ite
any injury or ot August 2, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium 2009 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, 7557 Wisconsin Avenue, Bethesda, 21. Signature of Funeral Service Licensee Bethesda-Chevy Chase, Inc. Maryland 20814 Ulillian a. M01173 Temp 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) **Physician** Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Records, P.O. certificate has been signed by the rector, page 2 should be detached 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Division of Vital 2 No 1 □Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medica 26. Place of Death (Check onl. one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 To the I 29b. Signature and 29d. Date signed (Month, Day, Year) July 31, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Joseph Rothstein, M.D. 8600 Old Georgetown Road, Bethesda, Maryland 20814 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

AUG 0 3 2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** unthia /Medical Eacility Name (If not institution, give street and number) City, Town, or Location of Death County of Death Examiner Date of Birth (Month, Day, Year) 7-24-194 7. Age (In yrs. last birthday) (State or Foreign 6. Sex **Funeral** Min Months Days Hours 1 □ M 2 1 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 7 Is marked other than "natural", or items 23a or 28a-f shot traumatic event, the thought from the foundation at 1 ☐Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 72 hours after □Yes 2 No 1 ☐Yes 2 No Blac Maryland 21215-0036 If Yes, Give Year or Dates: Specify 2 Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Callege (1-4or 5+) Year S Harford Co. City Osucil permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien. Important: If item 27 is marked other that any injury or other traumatic management.  $m \cdot \Lambda$ . 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gordon ST Stanci/ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kesrille, MD 21208 Milbred Br ickers Tapscot SISTER 4506 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 7-09 wood lawn, Mb odlan Cemater 4 Donation 5 Dother (Specify) igho c. Greene fingals 21. Signature of Funeral Service Licenses andallston, MD ZU33 728 best Approximate Interval Between Onset and Death 23a. Part 1. Enter the dis shock, or heart failur complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final **Physician** 8 months Varion disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-transit Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ØNo P.0. signed by the a d be detached f 9 Tuknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown icate has been sly ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 1 ☐ Yes 2 Ø No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2.☑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ္ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division of Vital Records,

State Registrar

Medical

29a. Certifier

Channing

29b. Signature and title of certifier

Paller

DHMH 17 Rev 1/2001

30. Name and address of pulson who completed cause of death (Item 23a) (Type, Print)

and manner stated.

, MD

Broad

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

120067713

Rm 1363 Baltimore, MD 21231

29d. Date signed (Month, Day, Year)

30

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09-05905	
Jayden Tre Smallwood	

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 24688

lyden ne oman	1-	For State Certificate of Death	Reg. No.	
Physiciar		. Decedent's Name (First, Middle,Last)	ate of Death	3. Time of Death  Year  0855 hrs
ledical Examin		OUNGET IT & SILVER	ily 28, 2009	c. County of Death
)	4	Sinai Hospital Baltimore		NIA
Funeral Director		215.85.6H3 1XM 2 F Vrs. Annual Days Hours Min. C		/DD/YYYY) 9. Birthplace (State or Foreign Country)
id how any cc.	1	Job Job County  MD Howard Columbia		10d. Inside City Limits 1 Yes 2 No
ith the Maryland 23a or 28a-f show	Director	106. Street and Number 106.92 Hickory Ridge Road 21044		tizen of What Country?
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	y Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black
hours after 'natural'', Examiner	⋧┞	Widowed 4 Divorced If Yes, Give Yeer or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	done 16b.	Kind of Business/Industry
21215-0036 uld be filed within 72 Montal Hygiene. marked other than "	Completed	17. Father's Name (First, Middle, Last) 18. Mother's Name (Fir		
4/ - 1 1	<u>ا ۾</u>	Tré R. Smallwood Chédo		
Sho and a sho	ို	Katrina M. Coistle Aunt 5831 Harpers Farm	Koad (	Dlumbia, MD : Location - City or Town, State
(1)		20a. Method of Disposition  1 Agurial 2 Cremation 3 Removal from State Crematory or other place)  1 Removal from State Crematory or other place)	1109 h	lindsor Mill, MD
Baltimore, pernit. Pages I a Department of He Important: If ite		21. Signature of Funeral Service Licensee 22. Name and Address of Facility \\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Banda	Steene FW) traising
Physician	7	23a. Part I. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or restable. List only one cause on each line.	spiratory arrest, s	hock, or heart Approximate Interval Between Onset and Death
Medical xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Sudden unexplained death in infancy (Sudden unexplained death in infancy)	SUDI)	
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		
ited d ansit	Examine	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.	30 TT	
60, rate be executed oblysician and re burial - transit	Medical	X <sub>UNPENDED</sub> 23a,27,28a-f,permE, g895 9/18/0		
Division of Vital Records, P.O. Box 68760, rothe Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)		23d. Date of delivery Month Day Year
Division of Vital Records, P.O. Box 687 and or Attending Physician: The law requires that the death certific an birrector: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as the	by Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		co use contribute to the cause of death?
cords, law requires has been sig	Completed		24a. Was an autopsy performer	
Rec : The ificate r, page		25. Was case referred to medical 26.Place of Death (Check onli		NO TES 2 NO
/ital	o Be	examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other Nursing I	Home 5 Res	sidence 6 Other:
n of \ding Phy. h. After the function of the function of the phy.	-	27. Manner of Death  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work? 28c. Injury at Work?	8d. Describe how unk	injury occurred
Division or Attend s after death. Director:	Certification:	2 Accident Investigation 3 Suicide 6 X Could not be determined (Specify) 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 Suicide 1 S	8f. Location (Stre or Town, State BAltimo	et and Number or Rutal Route Number, City b) 1008 N. Rosedale re. MD
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	4 ☐ Homicide  29a. Certifier (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only	ue to the cause(s	) and manner as stated.
To the within To the comple	Mec	29b. Signature and title of certifier  29c. License number  O.C.M.E.		gd. Date signed <i>(Month, Day</i> , Yea <i>r)</i> luly 29, 2009
		30. Name and actives of person who completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MI	 D 21201	
S	ate	24 Date filed (Month, Day Year) 32. Registrar's Signature	-	
Regis				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1 - State of Maryland / Department of Health and Mental Hygiene

1 - State of Maryland / Department of Health and Mental Hygiene

26 per verg., 8894-08/03/09dnb

Certificate of Death

Reg. No. 7 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year ER WHI 1:49PM **Physician** 25 09 JULIA /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) Examiner Woodington Date of Birth (Month, Day, Year)
8-28-/924 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Hours 1 □ M 2 🖼 169 12 3884 Director Usual Residence of Decedent 10a. State PA. 10d. Inside City Limits 10b. County 10c. City, Town or Location ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ res 2 ☐ No Philadelphia Funeral Director 10g. Citizen of What Country? 10f. Zip Code 19132 10e. Street and Number 2329 N. 25th St. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 No 3altimore, Maryland 21215-0036 Specify. Specify: Black ð 3 ☐ Widowed 4 ☑ Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Decedents Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

\*\*Sins Assistant Elementary/Secondary (0-12) College (1-4or 5+) NUrsins 18. Mother's Name (First, Middle, Maiden Surname) 17\_Eather's Name (First, Middle, Last) Be imond 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship Philli 3008 ROCKWOOD 140. MD21215 Hilda OUSIN 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition s Emetery 7-31-09 Balto. MD
22. Name and Address of Facility Vaughy C. Greene Fineral Services 1 Burial 2 ☐ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License Na Honal Pike Balto. MD21259 5151 Bal timore / Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) AIZHUMERS Dementia **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if an leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and burial-trar Due to (or as a consequence of) 本力な打ひた ナギンし Division of Vital Records, P.O. Box 68760, tending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Day Month Year 5 Other (specify) ☐Yes 2☐No the detached 9 D Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown dearbitus 1 🗌 Yes SACYA funeral director, page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 ➡No certificate 1 ☐ Yes 2 ☐ NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Assisted Hospital: 1 Yes 2 ₩6 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? After Injury 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Hospital or Attendi 24 hours after death. Funeral Director; A 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 ☐ Homicide within 24 hours a To the Funeral C If Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 35102 30, 2009 Wholly ammo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5901 North CHARLES STREET BALFINIOR MAYYIAND 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 3 2009 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 12,165-18 per fh 8894 8-11-09 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician 2009 Seaby July 30, 7:46 P Robert /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Dundalk 6809 Dunhill Road If Under 1 Year If Under 24 Hrs
Months Days Hours Min. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, **Funeral** 1**/**0 M 2□ F Months Days 218-16-1166 January 19, 1924 Maryland 85 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show 1 ☐ Yes 2 ☐ No permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mehald Hygien.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f st Important: It item 27 is marked other than "natural" or other traumatic event, Ite Modies Examinat must be notified any injury or other traumatic event, Ite Modies Examinat must be notified. Director Dundalk Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21222 USA 6809 Dunhill Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 3/43-6/44 1 □Yes 2 □ No Specify Specify: White 3 ₩ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Western Elementary/Secondary (0-12) College (1-4or 5+) <del>Westren</del> Electric 12 years Engineer ges 1 and 2 should be filed v t of Health and Mental Hygid If item 27 is marked other? 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Standsky Frank C. Seaby Andrew Stupavsky 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1908 Washington Road, Dundalk, Maryland Thomas Seaby son August 3, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Dundalk, Maryland 2009 Oak Lawn Cemetery 4 Donation 5 DOther (Specify) 22. Name and Address of Facility Connelly Funeral Home of Dundalk, P. A. 7110 Sollers Point Road, Dundalk, Maryland 21222 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or co or lications that caused the death. Du ot enter the mode of dying, such as cardiac in respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 0415 Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physiclan; The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) □Yes 2□No signed by the a d be detached f P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No ficate has been si Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 2 🗆 No certificate 1 ☐ Yes 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only she) Be Other: 4 \sum Nursing Home Hospital: 2 No 5 Residence 6 ☐ Other (Specify) Certification: To 1∐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 27. Mann Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: filled in by the 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 the 29d. Date signed (Month) Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person wh Dundalk, Avenue Danai 0 3 2

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

AUG

2009

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JULY **Physician** 04:51 AM 28 2009 ROSALIND SPALTER HONIG /Medical 4c. County of Death ARDEN COURTS MANOR CARE HEALTH 4b. City, Town, or Location of Death Examiner BALTIMORE PIKESVILLE Birthplace (State or Foreign Country)
 NY If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 02/09/1916 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days Hours 1 □ M 2 🕶 F 93 066-01-6134 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 a or 28a-f show any injury or other traumatic event, I'm Ma fical Examination must be notified at agnee. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2**X**☐ No Director MD BALTIMORE PIKESVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 8909 REISTERSTOWN ROAD 21208 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. 1 □Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: ð WHITE 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) **5+** Elementary/Secondary (0-12) GOVERNMENT SOCIAL WORKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) IJ0SEPH HONIG **JEANETTE** 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4224 OLD MILFORD MILL ROAD, BALTIMORE, MD 21208 BILLI DALE/DAUGHTER 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State KING SOLOMON CEMETERY 07/31/2009 CLIFTON, NJ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., Signature of Funeral Service 23a. Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final My herris **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Mo
9 Unknown 4 ☐ Pregnant at time of death 5 Other (specify) P.0. cate has been signed by the page 2 should be detached 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ tonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autop performe certificate 2 🗆 No 1 ☐ Yes ↑□Yes After this certification, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) MSiska Link 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death or Attending → Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mus Mille 30. Name and dress of person who completed cause of death (Item 23a) (Type, Print) Mille 25 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 8: 25M **Physician** Regina Barbara von Ulrich 2009 31 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Bel Air Upper Chesapeake Medical Center | Trunder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Feb. 2, 1935) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Maryland 216 30 5831 74 Director Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City, Town or Location 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "adical Event har than natified at 1 ☐ Yes 2 No Maryland Harford Edgewood Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21040 USA 36 Mallard Way Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🖾 No Specify. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Certified Public Accountant Accounting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frederick Wissing Emily Praley and № 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 36 Mallard Way Edgewood, Maryland 21040 Andrew von Ulrich (Husband) Injury or other Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 jo Jo 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 8/3/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 Pay 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** DED disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner P Due to (or as a consequence of). 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 ☐ Pregnant at time of death 5 Other (specify) the Ö 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 05+00 performe certificate 2 **%**0 1 ☐ Yes 2 ☐ No Vital )er ZEN 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA Medical Certification: To Division of 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 THomicide Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) 31. Date filed (Month), Day, Year) State AUG Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2009 12.05 AM July 30 Thomas Albert Varholy, Sr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Glen Burnie Under 1 Year | If Under 24 Hrs. Anne Arundel Glen Burnie Health & Rehab Center Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours XX M 2 F 219-30-7091 75 8/1/33 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 🗶 No Director MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 311 6th Avenue Completed by Funeral 21060 USA 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status YYYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes XX No Specify Specify: White XX Widowed 4 Divorced 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Brew Master Brewing Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Unknown John Varholy ဥ 19a. Informant's Name/Relationship (Type. Print)/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Michele Varholy-Charlsen 7846 Foxfarm Lane Glen Burnie, MD 21061 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition **X**Burial 2 ☐ Cremation 3 ☐ Removal from State 8/4/2009 Baltimore, MD 4 Donation 5 Other (Specify) Parkwood Cemetery 21. Signat re of Funeral Licensee 22. Name and Address of FacilitySingleton Funeral & Cremation M01220 Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 23a. Part T. Effet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNEUMONIA ASPIRATION Due to (or as a consequence of): Candidazio DOPPAGE Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) I ☐Yes 2 ☐ No 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by PAIN BACK 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 No 2/2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 A Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1-☑ Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

**Funeral** 

**Director** 

ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after i Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Evandres once.

**Physician** /Medical

Examiner

attending physician and for use as the burial-transit

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Baltimore, Maryland 21215-0036

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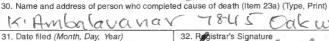
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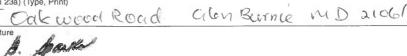
K. Ambalavanav 31. Date filed (Month, Day, Year) State Registrar

29a. Certifier

(Check only one)

29b. Signature and tele of certifie





1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D 51596 29d. Date signed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

show

To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlansit

State Registrar

Isha 31. Date filed (Month, Day, Year) 3

29b. Signature and title

Bhatnagor Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.



29c. License number

9641

N Greene Street

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month July **Physician** Wheeler Lydia Ray 29 2009 11:10 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A 1123 W. Hamburg St. Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 □ F 214-24-3940 April 29, 1929 Maryland 80 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√ Yes 2 No Director Baltimore N/A Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21230 1123 W. Hamburg St. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ∐Yes 2 TXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🛣 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edith Hadaway ပ William Swan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earl M. Wheeler, Sr. (Husband) 1123 W. Hamburg St., Baltimore, MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 8/3/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Coronany disease or condition resulting in death) Due to (or as a cons quence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 □No 3 Probably 4 Unknown Completed

**Physician** /Medical **Examiner** 

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", any injury or other traumatic event.

Baltimore, Maryland 21215-0036

If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be motified at

sician and burial-tran been signed by the attending physician should be detached for use as the buria completely filled in by the funeral director, page 2 should be

the Hospital or Attending Physician: The law requires that the death certificate be executed

has

certificate

within 24 hours after death.

To the Funeral Director: After this

Be

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Certification:

Medical

Division of Vital Records, P.O. Box 68760,

1 🗗 Yes	2
24a. Was an	
autopsy performed	?_
1 □ Yes 2 🗗	No

28d. Describe how injury occurred

26. Place of Death (Check only one

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referre examiner? 1 ☐ Yes 2 ☐ ✓	d to medica
27. Manner of Death	
1 Natural	5 Pendir

5 Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) July 30, 2009

31. Date filed (Month, Day, Year)

1120 Rulling North 32. Redistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** JULY 2009 03:20A M Francis Waldt, Thomas /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | 0ctober 6, 1 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 1 X M 2 □ F 56 220-60-7678 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 X No Director Maryland Baltimore Timonium 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 56 Gerard Avenue 21093 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 Never Married 2 Married 1 ☐Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: Specify: ģ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Distribution Manager Shipping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Medio Waldt. Mary Margaret White ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Lee Waldt / Wife 56 Gerard Avenue, Timonium, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Joseph Church
Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 08/03/2009 Cockeysville, Maryland 4 ☐ Donation 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21, Signature 1050 York Road, Towson, Maryland 21204 23a. Part 1. Enter the disease shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ACUTE MYOCARDIAL INFARCTION HOURS Due to (or as a consequence of) YEARS CORONARY ARTERY DISEASE E-quentially not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ HYPERTENSION 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performe 26. Place of Death (Check only one) 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier

Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar physician sthe burial Division of Vital Records, P.O. Box 68760, attending pl ned by the page 2 funeral director, 24 hours after death.

Funeral Director: #

To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be notified at another.

**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0036

6 V

State Registrar

29c. License number

29d. Date signed (Month, Day, Year)

TOWSON MARYLAND 21204

A Boren M.

D51852

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7601 OSLER DRIVE A. M. D.

31. Date filed (Month, Day, Year)

AUG 0 3 2009

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month WILLOW 625 AM 07 2000 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Worchester Atlantic General Hospital Berlin If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday)
55 yrs. 8. Date of Birth (Month, Day, Year) October 20, 1953 5. Social Security Number Days Maryland 1 □ M 2 🖺 F 215-62-5067 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 ☐ Yes 2X No Maryland | Montgomery Montgomery Village 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 20886 United States 8809 Eskridge Court 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pest Control Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Barbara M. Womack John C. Burkinshaw 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Melissa A. Roberts/Daughter 10218 Stagecoach Drive, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parklawn
Memorial Park August 2009 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ 21. Signature of Funeral Service Licenses Rockville, Inc. 300 West Rockville, Maryland 20850 Montgomery Avenue M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deathy Immediate Cause (Final Sounmons omon Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown

Physician /Medical **Examiner** 

Physician

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

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Saltimore, Maryland 21215-0036

burial-tran

signed by the attending physician be detached for use as the buria After this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, Physician/Medical

cate has been si page 2 should t

Division of Vital Nilson, Vickir

Records,

State Registrar

disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform penormed? 1 □Yes 2 No 1 ☐ Yes 2 MINo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation 1 □Yes 2 □ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 209

address of person who completed cause of death (Item 23a) (Type, Print) Raz

32. Registrar's Signature 31. Date filled (Month, Day, Year

29b. Signature and title of certific

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Ye ar **Physician** 2009 6:15 A<sup>M</sup> July 29 Javne Lee Werner /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 101 Glenn Hill Ct. Carroll Union Bridge If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 ☐ M 2 🕱 F Feb. 4, Director 61 1948 Indiana 315-50-1262 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mentai Hygiene. 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director Indianapolis Indiana Marion 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 8102 Garden Ridge Road 46237 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 □ Yes 2**K** No Specify 2 Specify: 3 Widowed 4 X Divorced White Completed marked other than "natur matic event, the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 shopping mall property cash receipts specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 7 Is marker traumatic Paul E. Bailey Berdie McCloud ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If Item 27 Is or other trau Amy Stambaugh/daughter 101 Glenn Hill Court Union Bridge, MD 21791 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page Department o Important: If I any Injury or once. 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State All County Cremation 7/30/2009 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service Licer athanie ( 6 E. Broadway Union Bridge, MD 21791 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause un each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Securitary list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physiclan: The law requires that the death certificate be executed physician and s the burial-trans Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy 2 3 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) residence Hospital: 1 ☐ Yes 3 1 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann f Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier

State Registrar 29b. Signature a

31. Date filed (Mo

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29d. Date signed (Month, Day, Year)

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and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12:56 AM 2009 STEVEN TERRYL WOODS July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Memorial Hospital Frederick Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1**∑** M 2□ F June 12,1956 Washington D.C. Director 53 216-68-2054 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be coffied at 1 ☐ Yes 2X No Director MD Frederick Woodsboro 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21798 10331 Woodsboro Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1♥]Yes 2 □ No 1Yes, Give Year or Dates:1973-1976 14. Race - American Indian, 11. Marital Status Black, White, etc. hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify ģ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) within 72 Elementary/Secondary (0-12) 12 is marked other than College (1-4or 5+) Yard Man Lumber 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be 1 Department of Health and Mental Important: If item 27 is marked o Lois Jeane Ruleman George F. Woods, Jr. 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Woodsboro, MD 21798 10331 Woodsboro Road Terry H. Woods/wife Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 5 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Injury All County Cremation 7/29/09 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Si vature of Fyrieral Service Licensee Hartzler Funeral HOme any. Jarine ( 404 S. Main St. Woodsboro, MD 21798 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physiclan** Aspergillosi /Medical Due to (or as a consequence of): Examiner Pseido mo nas Preumone Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami attending physician and Due to (or as a consequence of) Tobacco Physician/Medical IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 10 No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 □ Yes 2 ☑ No 1 ☐Yes 2 ☐ No certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 [] M 1 Tes 1 ☐ Unpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 Division of this in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred al or Attending Poster death.

I Director: After to Certification: 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral E completely filled 1 Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 MD MDD66166 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year) DHMH 17 Rev 1/2001

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32. Registrar's Signature Dinewa

400 W. 7th St. Frederick, MD 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1056 AM Physician Weeks 26 2009 Sahlil /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1 □ M 2 □ F 216-69-2343 2004 Maryland Apr.5. **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ms 23a or 28a-f show must be notified at 1

Yes 2 □ No Director Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code USA 21225 3028 Southland Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No 11. Marital Status Examiner 1 Never Married 2 Married filed within 72 hours after SpeBylack ō 1 ☐ Yes 2x No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: ģ 3 Widowed 4 Divorced ed other than "natural", event, the Medical Exar 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) and Mental Hygiene. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be file ment of Health and Mental Hy tant: If item 27 is marked oth Be Shannon Cornick Randy Weeks မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship *(Type, Print)* Marian Smallwood/Grandmother 3028 Southland Avenue Baltimore,Md 21225 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Department of hamportant: If ite any injury or of once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Zion Cemetery 8/3/09 Lansdowne, Maryland Mt. 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signatury of Funeral Service Licensee 5240 Reisterstown Road Baltimore,Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Caure (Final disease or condition resulting in death) Subarachnoid hemorrhage days **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and I for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, /Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery Physician/ 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? Pregnant at time of death igned by the att be detached for 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? s certificate has be director, page 2 s 1 Yes 2 🗌 No 1 TYes 26. Place of Death Che k onl one 25. Was case referred to medical in by the funeral director, æ examiner? Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 3 🗌 DOA 6 Other (Specify) 2 🗆 No 2 ER/Outpatient ٩ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: After Injury 1 X Natural 5 Pending 1 🗌 Yes 2 □ No investigation 2 ☐ Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide n 24 hours aft **e Funeral Di** bletelv filled ir the Hospital 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (check only within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D64882 July 26, 2009 LLD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 Nelson

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 03 2009

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parks

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		_1	For State Registrar	State of Mai	ryland	I / Departme <i>Certifica</i>			Mental Hy	giene Reg. No	711115	24701
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Exa Fune Direc			197-30-4117	AVC 7.Age	(In yrs. la	5	er 1 Year	ocation of Death	8. Date of Bin (Month, Da	th ay, Year)	Cou	
rryland			Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Location						10d. Inside City Limits
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ath with			1110 Tyler Ave				21804			иș		
036 urs after de al", or items		2	11. Marital Status  1 Never Married  2 Married  3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 10		1 DVas		panic Origin? (S , Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	)-	14. Race - Ameri Black, White, Specify:	
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_ = 0 '		-	Mary Louise Wallen/Wi	se		1110 Tyler	Ave .	Salisbury	MD 2180	)4		
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To th	MA		29b. Signature and title of certifier	all	M	2	9c. License	number	70	29d. Da	ate signed (Month	Pay, Year)
		- ;	30. Name and address of person who c	11 1111		23a) (Type, Print)	17	27 0	70	1	1	000
	State istrar		31. Date filed (Month, Day, Year)	32. Pegistran	s Signatu	10 150)	1	אל כנ	01150)	VVV	0 1	802

DHMH 17 Rev 1/2001

Physician /Medical Examiner The law requires that the death certificate be executed

filed within 72 hours after

Pages 1 and 2 should be

3altimore, Maryland 21215-0036

P.O. Box 68760,

Division or Vital Records,

or Attending Physician:

To the Hospitai

physician and the burial-tran attending p certificate has been signed by the rector, page 2 should be detached funeral director, After within 24 hours after death.

To the Funeral Director; /
completely filled in by the fi

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 € Residence 6 ☐ Other (Specify) 2 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month. Dav. Year)

State

29b. Signature

31. Date filed (Month, Day, Year)

AUG 0 3 2009

DHMH 17 Rev 1/2001

og Crossroads, #307

State of Maryland / Department of Health and Mental Hygiene

	•	for State Registrar		Cei	rtificate of L	Death	F	Reg. No.	19	21.70		
Physic	ian	1. Decedent's Name (First, Midd		kor			2. Date of Dea Month	Day	Year <b>009</b>	3. Time of Deat 12:10 p		
/Medi		4a. Facility Name (If not instituti	Irving M. Ba	aker	4b. City, Town, or	Location of Death	July	4c. County of				
Exami	ner	· ·	ry General Hospit	-a1	,	Olney		Mo	ntgom	Death  typomery  Birthplace (State or Fore Country)  Massachusetts  10d. Inside City Lington at Country?  U.S.A.  American Indian, White, etc.  White  mess/Industry  et Metal  ate, Zip Code)  and 20906  ty or Town, State  Approximate Interval Betwee Onset and Death  of delivery holds are autopsy findings aveor to completion of causath?  Yes 2 No  (Specify)  or Rural Route Number as stated.		
Funeral Director		5. Social Security Number 087-18-6821		(In yrs. last birthday) 83 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day March 1,	/, Year)	Cour	ntry)		
ryland thow		Usual Residence of Decedent  10a. State 10b. Count	у	10c. City, Town or Lo	cation				1			
e Ma Ba-f s	cto	Maryland 1	Montgomery			ilver Spri						
g = 1	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W				
s 23a	eral		Orchard Drive		Man Danadant of Li	20906	acify Voc or No	14 Page				
72 hours after death with the Maryland "natural", or Items 23a or 28a-f show price Exercities must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 🗓 Ma 3 □ Widowed 4 □ Divorce	If Yes, Give	lo	Was Decedent of Hi If Yes, specify Cuba 1 □Yes 2 🍱 No		Rican, etc.)	Black Specify:	, White,	etc.		
72 hour "natural	Completed I	15. Decede	ent's Education eest grade completed)	I (Give	dent's Usual Occupa kind of work done o DO NOT use retired	lurina most of work	ting	16b. Kind of Bu	siness/In			
be filed within 72 ho ntal Hygiene. d other than "natur event, the Modical	Comp	Elementary/Secondary (0-12)	College (1-4or 5-	+)	Mecha			Sh	eet M	letal		
e filed val Hygie	Be	17. Father's Name (First, Middle	e, Last)			18. Mother's Nam	e (First, Middle,	Maiden Surnam	e)			
	10	Abral	ham Baker				Celia I	Rosenthal				
s 1 and 2 should f Health and Mer tem 27 is marke other traumatic		19a. Informant's Name/Relation	nship (Type. Print)		ng Address (Street a							
1 and 2 Health em 27 i		Lucille Baker	- Wife		Pine Orcha							
Page: nent o ant: If i		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (	n 3 □ Removal from State	20b. Place of Disponsion Commetery, creed Judean Memory	sition (Name of matory or other plac orial Garden	i .	7/2009		-			
permit. Pag Department Important: I any injury o	1	21. Signature o Fund al Sirvici	e thin ee Verux	f. L.	2. Name and Addres <b>Hines-Rinal</b> <b>11800 New H</b>	di Funeral	Home, Inc	c. Lver Sp <b>ri</b> n	g, Ma	ryland 209		
		23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that caused st only one cause on each lin	the death. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory ar	rrest,		Interval Between		
Physician		Immediate Cause (Final disease or condition Connestive Heart Failure										
/Medical Examiner		resulting in death)  Due to (or as a consequence of):										
-xaiiiiiei	٠.	Sequentially list conditions,	b. Pneumoni	La a consequence of):								
led Isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			:11							
and and	xan	Due to (or as a consequence of):  Septially leading to immediate cause. Emer Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Sepsis  Due to (or as a consequence of):										
tificate be executed g physician and as the burial-transit	Acute Renal Failure											
Hospital or Attending Physician: The law requires that the death certific thours after death. Funeral Director: After this certificate has been signed by the attending I telled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	☐ Ectopic pregnanc ☐ Other (specify)	y		23d. Dat Mo				
ures that t signed by d be detac	5	Part II. Other significant condi	itions contributing to death bu	ut not resulting in the u	nderlying cause give	en in Part i.						
law requir as been s 2 should	Completed						24a. Was	an 24b.	Were aut	opsy findings avai		
: The la cate has	E O							rmed?	leath?			
certificate rector, pag	Be	25. Was case referred to medic examiner?	pal			26. Place of Dea						
nysio	일	1 Yes 2 X No	Hospital: 1 🗷 Inpatie	ent 2 ☐ ER/Outpatie	nt 3 DOA Oth	er: 4 🗆 Nursing H	ome 5 ☐ Resi	dence 6 □Oth	er (Spec	ify)		
th. :: After the funeral	ation:	27. Manner of Death 1   Natural 2   Accident  Natural 1   Natural 2   Accident	how injury occurr									
al or Attend s after death al Director; ad in by the f	Certification:	3 Suicide 6 Could not be 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Nu City or Town, State)								ral Route Number		
To the Hospital or within 24 hours after To the Funeral Directory completely filled in b	Medical (	29a. Certifier 1 🗷 Certify (Check only one) 2 Medic	ying Physician: To the best at Examiner: On the basis of and manner sta	f examination and/or ir	th occurred at the til nvestigation, in my o	me, date and place opinion, death occu	e, and due to the irred at the time,	cause(s) and made and place,	anner as and due	stated. to the cause(s)		
÷ = = 0	ĕ.	29b. Signature and title of certif	Tene hi	ch dont	29c. Licens	e number		29d. Date signe	d (Month	, Day, Year)		
			111111 1111	110 TOV	r C/I no	050171		Total	. 15	2000		
104		30 Name and address of pares	on who completed cause of d	eath (Item 23a) (Type		0059414		Ju	Ly 15,	2009		
		30. Name and addres, or person	on who completed cause of dakhmanin, M.D.,		Print)		Maryl and		ly 15,	, 2009		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month George Elmer Belden  $\mathsf{A}^\mathsf{M}$ 8:08 July\_19, 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 1⊠M 2□ F Months Days Hours Min 204-01-8315 89 February 12, 1920 Philadelphia, PA Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 X Yes 2 No Maryland | Prince George's Lanham 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 9311 Fontana Drive 20706 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No 14. Race - American Indian. Black, White, etc. 1 ⊠Yes 2 No If Yes, Give Year or Dates: 1943–1946 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🔀 No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Design Engineer Department of Defense 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles A. Belden Ellen Mandeville 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol A. Belden / Wife 9311 Fontana Drive, Lanham, MD 20706 Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 7/24/2009 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Ay Rogens 23a. Part 1. Enter the disease, se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ № 3 ☐ Probably 4 ☐ Unknown

**Physician** /Medical Examiner

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certificate

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I or Attending Physician: after death.

To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dii

The law requires that the death certificate be executed

Box 68760.

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of Vital Records,

Division

Department of Health Important: If Item 27 any injury or other to once.

**Physician** 

Examiner

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Product Examinating must be really due

/Medical

10a, State

Director

Funeral

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Completed

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Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury tiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performe 2- No 1 □Yes

Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1 Natural

2 Accident

29a, Certifier

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, 28b. Time of 5 Pending investigation

1 ☐ Yes 2 🗆 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

and manner stated 29b. Signature and title of certifier

1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

26. Place of Death (Check onl. one)

30. Name and address of person. who completed cause of death (Item 23a) (Type,

(-107/-15

2669

31. Date filed (Month, Day,

32. Registrar's Signatur

State Registrar 09-05810 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Laverne Bailey 1- For State Certificate of Death Reg. No Registrar Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician. Month Day July 25, 2009 1033 hrs Medical Examiner Laverne Bailev R. 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Hanover 7726 Mellow Court 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director New York M 2 XF Nov29, 1949 Yrs 064-42-3556 59 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 X No s 23a or 28a-f show e notified at once. 28a-f shov Maryland Hanover Anne Arunde with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7726 Mellow Court 21076 U.S.A. Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-"natural", or items If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. filed within 72 hours after death Armed Forces? 1 X Never Married 2 Married 2 X No Yes Widowed If Yes, Give Year Yes 2 X No specify: Specify: Black 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) item 27 is marked other than 'traumatic event, the Medical Disabled 1 and 2 should be filed within Health and Mental Hygiene. Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Dixon Arthur Shelton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Zeneth Way Clinton, Maryland 20736 Elizabeth H. Dixon 7609 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 20a. Method of Disposition more, Pinelawn Memorial X Burial 2 Cremation 3 Removal from State Pages 1 Department of Important: I 7-31-09 Farmingdale,New York Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Marzullo Funeral Chapel, P. A 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Physician /Medical Death Sudden cardiac death xaminer or condition resulting in death) Due to (or as a consequence of) b. Myocardial fibrosis Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and trans X AMENDED #2,PI line a-b,PII,27,perME, g896 10/26/09 TT Physician/Medical X UNPENDED Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 V No 9 Unknown q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Ö ð 1 Yes 2 No 3 Probably 4 ✔ Unknown Δ. Acute bronchopneumonia; diabetes mellitus Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 Yes 2 1 🗸 Yes No Hospital or Attending Physician: 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be examiner? Hospital: 1 Other; Residence 6 Other: Scene ER/Outpatient 3 Nursing Home 5 Inpatient 2 this 1 ✓ Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After 27. Manner of Death 28b. Time of Injury Certification 1 X Natural Division n 24 hours after death.

he Funeral Director: A
bletely filled in by the fi 1 Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier July 26, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Russell Alexander MD. Assistant Medical Examiner 31. Date filed (Month Pay, 32. Registrar's Signature State artech RABARA Registra

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of F <i>rtificate of I</i>			eg. No.	3 24705	
	Physici	an	1. Decedent's Name (First, Midd	lle, Last)				2. Date of Deat		3. Time of Death	
-	/Medic		Sarah S. Ca					Month 07	11 2009		
1	Examin	er	4a. Facility Name (If not institution	-			r Location of Death		4c. County of Dea		
- Series			Montgomery G  5. Social Security Number	<del> </del>	ta⊥ le (In yrs. last birthday)	Olney If Under 1 Year	If Under 24 Hrs.	8 Date of Birth	Montgon		
	Funeral Director		170-10-6088 Usual Residence of Decedent	1 □ M 2√ □ E	96 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day 08-28-	Year) C 1912 ]	thplace (State or Foreign ountry) PA	
	yland how		10a. State 10b. County	4	10c. City, Town or Lo	ocation				10d. Inside City Limits	
	e Mar	Director	MD Montg	omery	Silver	Spring				1X Yes 2 □ No	
	青 5 6 7 8 8	Dire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	ountry?	
	ath w	ral	3700 Interna			20906			USA		
9	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evaring must be routiled at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Ma	12. Was Decedent Armed Forces? 1 ☐ Yes 2 X If Yes, Give	No	Was Decedent of H If Yes, specify Cuba 1 □ Yes 24 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)	14. Race - Am Black, Whit		
003	ours :	d by	3 X Widowed 4 □ Divorce	d Year or Dates:		TLITES 241110	эреспу.			ite	
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9	filed Hygi other ent,		17. Father's Name (First, Middle	<u>'</u>		LIBIALIA	18. Mother's Nam	e (First, Middle, I	<u>Medical</u> Maiden Surname)		
lan	lld be fental rked (	To Be	Bernard Seit	Z			Lena	Rosenber	g		
ary	shou and N s mar	-	19a. Informant's Name/Relation	ship (Type. Print)	19b. Maili	ng Address (Street	and Number or Rui	ral Route Number	r, City or Town, State,	Zip Code)	
Σ	Pages 1 and 2 ment of Health ant: If Item 27 is ury or other tra		Myra Rosentha	al / daughtei	- 1	.6617 Musi	ic Grove	Ct. Rock	ville, MD	20853	
ore	of He of He or oth	1	20a. Method of Disposition 1X Burial 2 ☐ Cremation	2 Demoved from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place	ce)	Date	20c. Location - City or	Town, State	
Ë	. Pag tment tant: jury o		4 Donation 5 Other (	Specify)					Adelphi, N		
Baltimore, Maryland 21215-0036	permit. Page Department of Important: If any injury or once.	. /	21. Signatur of Funeral Service	Licensee	1 CE 01491 2			_	el Funeral ville, MD	Direction, In 20852	
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99	rtifica ng ph as th		IE EEMALE.								
Division of Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death cert with 24 hours after death.  To thin Exhaust Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ☒No 9 □ Unknown		23d. Date of de Month	elivery Day Year					
σ.	uires that the de signed by the a Id be detached f		Part II. Other significant condit	ions contributing to death b	23e. Did tol	bacco use contribute t	o the cause of death?				
rds	w requires s been sign should be	Completed by		Heart Failur				1 □ Y€	es 2 <b>1</b> No 3 □ F	robably 4 🗌 Unknown	
ecc	e law re has be	plet	Atrial Fibri	lation				24a. Was a		utopsy findings available	
<u> </u>	ician: The certificate hi rector, page	Mo						autops perforr 1 □ Yes	ned? death?	completion of cause of s 2 □ No	
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ono	nding Phith.: After thie funeral	ation:	27. Manner of Death  1 ☑ Natural 5 ☐ Pendii 2 ☐ Accident invest	ng 28a. Date of Inju (Month, Da igation	y, Year) 28b. Time o	Work	yat <br Yes 2 □ No	28d. Describe ho	ow injury occurred		
Divis	l or Atte after des Director I in by th	Certification:	3 Suicide 6 Could 4 Homicide deterr	not be mined 28e. Place of Inj building, et	ury - At home, farm, st c. (Specify)	reet, factory, office			treet and Number or Rural Route Number, n, State)		
	the Hospital or Atten hin 24 hours after deat the Funeral Director: mpletely filled in by the	Medical C	29a. Certifier 1 Certifyi (Check only one) 2 Medica	ing Physician: To the best	of examination and/or in	th occurred at the tir	me, date and place pinion, death occur	, and due to the c	ause(s) and manner a late and place, and du	is stated. e to the cause(s)	
	o the vithin (	Mec	29b. Signature and title of certific	and manner st		29c. Licenso	e number	2	9d. Date signed (Mon	th, Day, Year)	
	150		> Stens	) MO, FACE	?	D005	58770		07/11/21		
			30. Name and address of persor				мо	20832			
	Sta	0	Jeremy Graf, M 31. Date filed (Month, Day, Year,		ar's Signature	Ur. VINC	YI MD	LO 3 3 E			
	Registr		JUL 202		A. par	w					

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29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) 2009 **Physician** 1210PM HINCKLEY JUL 26 rich ard /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and numb Examiner Baltimore 1202 St. Andrews Way Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay, Year) | 6/24/57 Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 № M 2 🗆 F Maryland 52 003-36-8505 Director Usuel Residence of Decedent 10d. Inside City Limits the Maryland 10c. City. Town or Location 10a. State 10b. County or 28a-f show r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Baltimore Baltimore. MD Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21239 1202 St. Andrews Way death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be fited within 72 hours after 1 Never Married 2 Married or ! White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify. þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Johns Hopkins Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be fited within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mones. Bauview Hospital Psychiatric Nurse 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Martha Hockersmith Richard H. Cox, Sr. ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1202 St Andrews Way, Baltimore, MD 21239 Andrea J. Cox/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 7/28/09 Smithsburg. MD \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 12525 Bradbury Ave. J.L. Davis Funeral Home Smithsburg, Md. 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ASTROINTESTINA Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner FUE YEARS P E Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of) P.O. Box 68760. attending physician þ Physician/Medical the or Attending Physician: The law requires that the death certificate IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 X No 3 Probably 4 Unknown 1 🗌 Yes cate has been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed2 2 No 1 Yes 1 Tes 22 No Be 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Medical Certification: After 5 Pending investigation Natural To the noop after death.

Within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) the e

State Registrar

29b. Signature and title of certifier

30. Name and address of person AROL ANN

31. Date filed (Month, Qay, Year) 32. Registrar's Signature

ted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

1650 OPUBANS STREET #242 BAVIMONO, MB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) CHENG **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Ellicott City Ellicott City Nursing & Rehab Howard If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Hours 12/22/1924 Director China <u> 214-60-1409</u> Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Director Howard Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code by Funeral 6150 Foreland Garth Apt. 414 21045 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Mamied Baltimore, Maryland 21215-0036 1 □ Yes 2 No Specify 3 Widowed 4 Divorced Chinese Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 self employed restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Unknown ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Chin Yang - Daughter 6102 Starburn Path Columbia, MD 21045 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crematory 7/27/09 Hanover, MD 21. Signature of Functal Se viol Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 M01411 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 TYes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 4 ☐ No 24a. Was an autopsy performed 21 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 1 No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director; After thi
completely filled in by the funeral. 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital or the Hospital of the Hours af 29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dav. Year)

(5)

State Registrar 30 Name and address of person

31. Date filed (Month

32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

rar's Signature

L. Sparke

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 12:15 PM Stephen Vincent Catalano, Jr. 2009 July 17, /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gladys Spellman Nursing Home Prince George's Cheverly If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 M 2 □ F Yrs. 59 November 15, 1949 Washington, 219-48-7902 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10b. County 10c. City, Town or Location r than "neturel", or items 23a or 28e-f show the Medical Examiner must be notified at 1 X Yes 2 No Maryland Prince George's Cheverly Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2900 Mercy Lane 20785 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Mamed 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bureau of Elementary/Secondary (0-12) College (1-4or 5+) other than Engraving and Printing Book Binder 12 traumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental and Mental Stephen V. Catalano, Sr. Helen A. Heil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 23162 Pine Run, Millsboro, DE 19966 Concetta M. Simms / Sister other 20c. Location - City or Town, Stete 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages 1:
Department of He Important: If item any injury or other 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 7/22/2009 Fort Lincoln Cemetery Brentwood, Maryland \*4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue Nasch Gasch's Funeral Home, P.A. Hyattsville, MD 20781 slance 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Myocardial Infarction Hours **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner b Septic Shock Days Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Days Acute Pneumonia burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Months Physician/Medical Multiple Decubitus Ulcers the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) o. detached 9 Unknown 9 Unknown ۵ been signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, δ 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Acute Respiratory Failure on Ventilator, Diabetes Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? Mellitus Non Insulin Dependent, Coronary Artery Disease, page 2 certificate has 2 No Paroxysmal Atrial Fibrillation 1 Tyes 1 Yes 2 🔯 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) funeral director Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify) Certification: To 1 ☐ Yes 2 🔀 No this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. Injury at Work? or Attanding 1 X Natural 5 Pending 1 Tyes 2 No within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date sinned (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Lealings 7/20/2009 D24720 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6132 Landover Road, Cheverly, MD 20785 Ravinder K. Rustagi, 31. Date filed (Month 32. Registrar's Signature JUL 2 1 2009 State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Robert Stewart Durham, Jr. July 18 2009 1510 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot Memorial Hospital at 5. Social Security Number 6. Sex Easton Easton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F 80 Director 213-28-5962 July 12, 1929 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It a Modical Examinar must be rediffed at once. 1 ☐ Yes X No MD Caroline Federalsburg Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 27480 Possum Hill Road 21632 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: White ģ If Yes, Give Year or Dates: 151-53 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Durham's Market G.E.D. Owner and Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Stewart Durham, Sr. Kathleen Alheit 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria H. Durham/Spouse 27480 Possum Hill Rd.Federalsburg, MD 21632 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 🖫 Cremation 3 ☐ Removal from State 7/22/2009 Federalsburg, Concord Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility F ramptom F uneral H ome, 216 North Main St. Federalsburg, MD 21634 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician resulting in death) /Medical Due to r as a consequence of) **Examiner** Metastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ending physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760 Physician/Medical signed by the attending g IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 K No 1 ☐Yes 2 No Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day, Year) 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a, Certifier 🗷 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I within 2 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

Date filed (Month, Day,

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Washington St, Easton, MD 21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 11:52AM Danes 2009 Musgrove /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 1 Year If Under 24 Hrs. Wi comico tospice at 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, ) 3-1-1922 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Days Months 1 □ M 2 🗓 F 87 Yrs. Director 214-16-5808 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ?7 is marked other than "natural", or items 23a or 28a-f show traumanc event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Wicomico Salisbury 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with USA 1110 Healthway Drive 21804 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: ≥ 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) per it. Pages 1 and 2 should be filed within Der artment of Health and Mental Hygiene. Important: if item 27 is marked other than "any injury or other trauma ic event, the Magnic." Elementary/Secondary (0-12) College (1-4or 5+) Board of Education Cafeteria Worker 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gleason Musgrove Mary ပ William . 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) <u>Linda C. McKenzie - Daughter</u> 35 Oak Hill Drive, Dunn, North Carolina 28334 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springhill Memory Gds: 7-21-2009 Hebron, Maryland 22. Name and Address of Facility Bounds Funeral Home 21. Signature 704 E. Main Street, Salisbury, Maryland 21804 Approximate Interval Between Onset and Death 23a. Part . Enter the disease, or complication shock, or heart failure. List only one complications are complicated as the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the com ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line Immediate Cause (Final disease or condition resulting in death) DRMBNTIA ADVANCED **Physician** /Medical Due to (or as a consequence of); **Examiner** NRUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Director for as a consequence of Examiner be executed and burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical law requires that the death certificate 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐ Pregnant at time of death 9☐ Unknown 5 Other (specify) signed by the a d be detached for □Yes 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown icate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate ha 1 ☐ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence Geother (Specify) HOSPICE 1 Yes 2/ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Notice 10 the forms after death.

To the Funeral Director: After Ameral Director: After Ameral Director: After Ameral Director: After Ameral Willed in by the fu 1 ☐ Yes 2 ☐ No 72 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number ဂ္ဂ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar P.U BUX1733

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3:13 DM **Physician** 3 9000 Glandon. Edward Davis /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner albot inston Memorial Hospital 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) October 14,1933 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours Maryland 1 ★ M 2 □ F 220-32-8317 Director Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location death with the Maryland 10a. State ral", or items 23a or 28a-f show 1 ☐ Yes 2X No Director Maryland Caroline Denton 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21629 United States of America 10290 Log Cabin Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2 □XNo Specify Specify: <u>6</u> Caucasian 3 ₩ Widowed 4 Divorced "natural", Completed th and Mental Hygiene.
7 is marked other than "natur traumatic event, the Medical 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sea Food Processing Receiving Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Matilda Knaack Haze1 Wright Leslie Davis ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) PO Box 164, East New Market, Maryland Son 21631 Department of Health Important: If item 27 any injury or other trooner. Edward E. Davis 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State Greenmount Cemetery 7/28/2009 4 □ Donation 5 □ Other (Specify) Hillsboro, Maryland 22. Name and Address of Facility
Moore Funeral Home, P.A. 21. Signature of Funeral Service Licenses 12 South Second Street, Denton, Maryland 21629 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ser Physician disease or condition resulting in death) /Medical Dus to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3☐ Probably 4 🖫 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 2 No 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 \( \Bigcap \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Mann f Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

State Registrar nd address of person who completed cause of death (Item 23a) (Type

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 8:14 PM nh 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard County General Hospital Columbia Howard If Under 1 Year \_ If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday, **Funeral** 8. Date of Birth (Month, Day, Year) 1 ☑ M 2 □ F Months Days Hours Min. Director 586-10-4391 60 Feb. 15, 1949 Vietnam Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at Director 1 ☐Yes 2X No Mt. Airy Marvland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16220 Compromise Court 21771 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes. Give ģ Specify. Specify: 3 Widowed 4 Divorced Year or Dates: Asian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit. Department of Health and Mental Hygien. Important: If Item 27 is marked other tha any Injury or other traumatic event, Italy once. 12 Owner/Operator Produce Business 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Khai Van Do Chu Truong 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phung C. Lin / Wife 16220 Compromise Court, Mt. Airy, Maryland 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Stauffer Crematory Inc.7/16/2009 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Juneral Service License 22. Name and Address of Facility Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, Marland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Seps~ Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical **Examiner** Gastric Cancel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physiclan: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ has been si je 2 should t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate ha irector, page 3 autopsy performed 1 □Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manny of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation nours after death.

neral Director: A
filled in by the for 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of cod 29c. License number 29d. Date signed (Month, Day, Year) 00063653

Registrar

State

55

32. Registrar's Signature

Lone Columbia, Maryland 21044

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009 ▶

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July 13, Day 2009 **Physician** Elsie Edmonds 2:47 a M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) last birthday **Funeral** Months Days 1 ☐ M 2 🛣 F 19, 1949 D. C. 577-68-8944 Dec. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 1 XYes 2 ☐ No Washington D. C. Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20017 U. S. A. 535 Edgewood Street, N. E. Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23 ant: It yo rother traumatic event, Ire Modical Exturns rough 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates: à 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales Associate 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Edmonds Unknown ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Washington, DC 20017 535 Edgewood St., N.E. #11 (Daughter) Elaine Brawner 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of I Important: If ite any injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Chesapeake Crematory 07/23/2009 Beltsville, Md, 4 ☐ Donation 5 ☐ Other (Specify) Sonatule of Function Service Libensee 22. Name and Address of Facility W. H. Bacon Funeral Home, Washington, D. C. 20010 Inc. 3447 14th Street, N.W. 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, how, or heaft failure. List only one/cause on each line.

In the cau (Final discusse or condition resulting in death)

Due to (or as a consequence of): Approximate Interval Between Onset and Death ysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical attending | for use as 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Vear Month 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>&</u> sign be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown Completed page 2 should disease Celeblorescoler 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A 2 Accident filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 ho To the Fune completely f (Check only

State Registrar

31. Date filed (Month, Day, JUL 2 1 2009

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 743 Summerwalk Dr. 32. Registrar's Signature

and manner stated.

DHMH 17 Rev 1/2001

D0064624

MD

29d. Date signed (Month, Day, Year)

Gaithersburg, Md. 20878

13,2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** July 18 2009 Anne Elaine Garrett 2:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Washington County

8. Date of Birth (Month, Day, Year)

March 20,1946 of Columbia 13040 Little Hayden Circle Hagerstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 🗓 F 212-52-0496 63 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County 28a-f show r than "natural", or items 23a or 28a-f shov 1 ☐ Yes 久 No Director Maryland Washington County Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13040 Little Hayden Circle 21742 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: Specify: Specify: White \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) is marked other than College (1-4or 5+) Registered Nurse Hospital permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important; If item 27 is marked other any Injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard Jeffries Garrett Annie Virginia Claggett 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard E. Garrett-brother 13030 Little Hayden Circle Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parklawn Memorial
Garden Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 7-25-2009 |Rockville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Fuenral Home Caitless 1331 Eastern Blvd. North Hagerstown, MD 21742 a 23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a conjequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as the ! for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 □Yes 2 □No detached 9 Unknown 9 \ Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐Yes 2 ☐No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 **□**₩б 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27, Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier cause of death (Item 23a) (Type, Print)

05H-10 State

JUL 22 31. Date filed (Month)

LP.

30. Name and address of person who co

P#gistrar's Signature

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DHMH 17 Rev 1/2001

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 9:30 РМ 2009 Myrtle Lois Groves July 16, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crofton Care and Rehab Center Anne Arundel Crofton If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Min. Days Hours 1 □ M 2 🖾 F 92 220-32-6527 January 10, 1917 Burnleys, VA Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Director 1 X Yes 2 ☐ No Maryland Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21114 USA 2131 Davidsonville Road Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Armed Forces? 1 □Yes 2 🗷 No Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates: Specify. þ Specify: White 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hyattsville Elementary/Secondary (0-12) College (1-4or 5+) Elementary School Cafeteria Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Leslie Cason Addie Elmo Barden 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary A. Groves / Son 1128 Rutland View Drive, Davidsonville, MD 21035 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 7/21/2009 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Faneral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue tons Gasch's Funeral Home, P.A. Hyattsville, MD 20781 an 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Cerebral Vascular Accident Weeks /Medical Due to (or as a consequence of) Alzheimer's Dementia Years Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Diserto for as a consequence off Due to (or as a consequence of): Physician/Medical F FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 🖾 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 □Yes 2 X No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖾 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year)

**Examiner** executed and Box 68760, attending physician certificate be the jo P.0. the þ signed I page 2 should

ed other than "natural", or Items 23a or 28a-f show event, the Wedical Examinari, and be notified at

within 72 hours after

2 should be filed v and Mental Hygis is marked other i

permit. Pages 1 and 2 should be Department of Health and Mentis Important: If Item 27 is marked any Injury or other traumatic events.

Baltimore, Maryland 21215-0036

certificate After this certific funeral director,

Records, Division of Vital Physician: ospital or Attending I n 24 hours arter content of Funeral Director: Af Hospital npletely To the I within 24

State

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) actitioner 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R06848 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28c. Injury at Work?

1 ☐Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Millie Jarrell,

27. Manner of Death

1 🛛 Natural

2 Accident

3 Suicide

29a, Certifier

4 Homicide

14300 Gallant Fox Lane, Suite #222, Bowie, MD 20715 31. Date filed (Month, Day, Year)

CRNP

5 Pending

investigation

determined

6 ☐ Could not be

Registrar

DHMH 17 Rev 1/2001

Registrar

nermit Pages 1 and 2 should be filed within 72 hours after death with the Manyland		
Department of Health and Mental Hydiene.	F Di	
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	un re	E X
any injury or other traumatic event, the Medical Examiner must be notified at	er	aii
once.	al or	111
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Baltimore, Maryland 21215-0036

Physic /Medi

e death certificate be executed	he attending physician and ed for use as the burial-transit
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
To the Hospital or Attending Ph within 24 hours after death.	<b>To the Funeral Director:</b> After th completely filled in by the funeral

Division of Vital Records, P.O. Box 68760,

Physician /Medical

	1 - State Registrar	Certificate of Death	) R	eg. No. 2009 24/10
	1. Decedent's Name (First, Middle, Last)		2. Date of Dear	m 37
ian cal	Lillian Hinds		July 16	$_{5},_{2009}^{\text{Day}}$   11:05 A <sub>M</sub>
ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location	of Death	4c. County of Death
	12117 Mackell Lane	Bowie		Prince George's
	5. Social Security Number 6. Sex 7. Age (In yrs. las	Months Days Hours	r 24 Hrs. 8. Date of Birth Min. (Month, Day	Year) Country)
	193-28-7175	Yrs.	Nov. 19	,1936   Pennsylvania
	Usual Residence of Decedent  10a, State 10b, County 10c, City,	Town or Location		10d. Inside City Limits
5				1 □ Yes 2/CYNo
ect	Maryland   Prince Georges   Bowi			
ä	10e. Street and Number	10f. Zip Code		0g. Citizen of What Country?
eral	12117 Mackell Lane	20715		U.S.A
Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2√3/No	13. Was Decedent of Hispanic O If Yes, specify Cuban, Mexica	n, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
		1 □Yes 2 1 No Specify	<i>/:</i>	Specify: White
Completed by	15. Decedent's Education	16a. Decedent's Usual Occupation		16b. Kind of Business/Industry
plet	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during mo life. DO NOT use retired)	st of working	
E	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker		Homeowner
Be C	17. Father's Name (First, Middle, Last)		ner's Name (First, Middle, I	
TO E		Anna	a Urin	
		19b. Mailing Address (Street and Numi	ber or Rural Route Number	r, City or Town, State, Zip Code)
	Bonnie Jackson (Daughter)	12705 Thrush Pl. 1	Upper Marlbo	ro, MD 20772
		ce of Disposition (Name of netery, crematory or other place)	Date	20c. Location - City or Town, State
	1 M Burial 2 Cremation 3 Hemoval from State		Iu1v 20. 2009	9 Clinton, MD
	21. Signature of Funeral Service Licensee	22. Name and Address of Facil	lity Los Europe	l Home Tre
	I whice h amount	6633 Old Alexa	ndria Ferry l	Rd. Clinton, MD 20735
	23a. P. 1. Enter the disease, or complications that caused the death.			
	shock, or heart failure. List only one cause on each line. Immediate Cause (Final			Onset and Death
	disease or condition resulting in death)  Due to (or as a consequent of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the contr	nce of):		
	Bus to (or us a sombsquer	100 01/1		
ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequer	nce of):		
Ē	if any, leading to immediate cause. Enter Underlying Cause (Disease on injury that initiated events			
Exa	resulting in death) Last Due to (or as a consequent	nce of):		
ca	d			
Medical Examiner	Park I	ACCUSED TO SECURE	70-2-077	
				23d. Date of delivery
Completed by Physician	in the past 12 months?  1			Month Day Year
hys	9 Unknown			
y P	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part	I. 23e. Did to	bacco use contribute to the cause of death?
pa	l <u></u> -		1 🗆 Ye	es 2 No 3 Probably 4 Unknown
Set			24a. Was a	
l E		<del></del>	autops perfori	med? death?
BeC	25. Was case referred to medical	26 Plac	1 ☐ Yes e of Death (Check only on	2 ☐ No 1 ☐ Yes 2 ☐ No
	examiner?  1 Yes 2 To Hospital: 1 Inpatient 2 EF	Othori		ence 6 ☐Other (Specify)
Ë	27. Manner of Death 28a. Date of Injury 28	Bb. Time of 28c. Injury at		ow injury occurred
ațio	1 Matural 5 Pending (Month, Day, Year) 2 Accident investigation	Injury   Work? M 1 ☐ Yes 2 ☐	]No	
ij	3 ☐ Suicide 4 ☐ Homicide  3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office	28f. Location (S	treet and Number or Rural Route Number,
Sert	building, etc. ( <i>Specify</i> )		City or Town	n, State)
) lex	29a. Certifier  1 Certifying Physician: To the best of my knowled	edge, death occurred at the time, date a	and place, and due to the	ause(s) and manner as stated.
Medical Certification: To	(Check only one)  2 Medical Examiner: On the basis of examination and manner stated.	n and/or investigation, in my opinion, de	eath occurred at the time, d	ate and place, and due to the cause(s)
Ž	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
	I for our	82192	5	7/17/09
	30. Name and address of person who completed cause of death (Item 23)		-	
	Delbert L. Perkins, M.D. 9560	Pennsylvania Ave	#106, Upper	Marlboro, MD 20772
ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	е		
ar	JUL 20 2009 Janear	a. Sarke		

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JULY 2009 1:30P.M. 20, Helen Mary Henson 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Washington Reeders Memorial Home Boonsboro 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Min 1 □ M 2 🕅 F Maryland 97 July 11, 1912 220-16-3789 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Maryland Washington Boonsboro 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 141 South Main Street 21713 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2X No Specify If Yes. Give 3 Nidowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nervin J. Brandt Eva Mae Owen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8873 Washington Street Savage, Maryland 20763 James W. Henson / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 07-25-09 Manor Cemetery Boonsboro, Maryland Bast-Stauffer Funeral Home, P.A. 7606 Old National Pike Boonsboro, MD 21713 23a. Part1. A ter the disease, or complications, or heart failure. List only on the complication of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex of the complex ony that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Infave tren 2 Hes Myccordiel disease or condition resulting in death) Due to or as a consequence of) DISEASE YLANNY charact Se quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Ithrul hib ullation Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death
Pregnant at time of death 3 🗆 Ectopic pregnancy Month 5 Other (specify) 1 □Yes 2 □No 9 □ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☑No 24a, Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

**Physician** /Medical Examiner Examiner

Department of Health an Important; If item 27 is any injury or other trauonce.

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

**Director** 

-28a-f

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or items 23a

'natural",

and Mental Hygiene.

traumatic event, the Medical Examiner must be notified at

Funeral Director

Completed by

Be

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death with the Maryland

filed within 72 hours after

2 should be

Pages 1 and Baltimore,

permit.

P.O. Box 68760.

Division of Vital Records,

Maryland 21215-0036

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To Be Completed by Physician/Me
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27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-trar Certification: death. ours after death.

neral Director: A
filled in by the fu within 24 hours a

State Registrar

5 Pending

6 Could not be

determined

(M)

and manner stated

28a. Date of Injury (Month, Day, Year)

29c. License number

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

4656

1 □Yes 2 □ No

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAPPANS ROAD, BOONSBORO, MARYLAND 21713 301-432-8470 GHAZALA QADIR, 20311 32. Registrar's Signature

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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** JULY 2009 1620 HEWITT Α. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MONTGOMERY HOLY CROSS HOSPITAL SILVERSPRING If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1**∑** M 2 □ F 69 579-52-0689 Director 12-30-1939 WASHINGTON, DC Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County ייפיו בני וא marked other than "natural", or items 23a or 28a-f show other traumatic event, I've Medical Exacting must be notified at 10a. State M∑Yes 2 No DC WASHINGTON Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20032 U.S.A. Funeral 216 MALCOLM AVENUE S.E. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. be filed within 72 hours after on the Hygiene.

ed other than "natural", or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify Completed by Specify. 3 Widowed 4 Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT BOILER ENGINEER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be of Health and Mental item 27 Is marked o EDITH SHORTER r LEON A. HEWITT SR. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 216 MALCOLM AVENUE S.E. WASHINGTON, DC 20032 ELLEN M. HEWITT/WIFE 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Pages 1 Department of H Important: If ite any Injury or ot once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Jul 18 2009 Harmony Memorial Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Road, Landover, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Severe Cardiomyopathy disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. (Disease or injury Examiner Due to (or as a consequence of) the death certificate be executed and that initiated events burial-tra resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy n the past 12 months? 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Acute Renal Failure, Hypotension 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown Completed Arrhythmia 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform this certificate 1 ☐ Yes 2X No 1 ☐ Yes 2 🖾 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1

Inpatient 2 □ ER/Outpatient 3 □ DOA Medical Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7/13/2009 D 68126 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rupinder Jeet S. Sandho, 1500 Forest Glem Road, Silver Spring, MD 20910 31. Date filed (Month, Day State JUL 2 1 Registrar

DHMH 17 Rev 1/2001

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Division of Vital Records,

			For State Registrar	State of Marylan		rtment of F tificate of			giene Reg. No.	2009	21.721
	Physici	an	1. Decedent's Name (First, Middle, Last)	nn Hartsock				2. Date of Dea	ith Day	Year	3. Time of Death
and a	/Medic	al	Shirley A			4b City Town o	r Location of Deat	July 2		2009 Year County of Death	1:03 PM M
a.c.	Examin	er	603 Himes Avenue,			Frederi	.ck			Frederick	
ł	Funeral Director		407 30 1070	7. Age (In yrs. I	a <i>st birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min,		9, 1	.934 Teni	lace (State or Foreign htry) 165566
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Loc	eation				1	0d. Inside City Limits
	e Mar) Ba-fsh Hifkd	Director	Maryland Frederic	.k Fr	ederio	k					XXYes 2□No
	th with th		10e. Street and Number 603 Himes Avenue	e, Unit 103		10f. Zip Code 217	'03		-	zen of What Cour	itry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, It a Marient Examiner must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married 3 XWidowed 4 Divorced	2. Was Decedent Ever in U.\$ Armed Forces? 1 ∐Yes Ž∐No If Yes, Give Year or Dates:		Vas Decedent of H Yes, specify Cub □Yes 2XNo	dispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		14. Race - Americ Black, White, Specify: W	
altimore, Maryland 21215-0036	within 72 ho iene. • than "natur fro Malical I	Be Completed	15. Decedent's Educ (Specify only highest grade	ation completed) College (1-4or 5+)	(Give life. L	lent's Usual Occup kind of work done DO NOT use retire Iomemake	during most of word)	rking		nd of Business/Ind vn Home	dustry
land 2	uld be filed Aental Hyg rked other Iic event, I	To Be C	17. Father's Name (First, Middle, Last) William Clint	on Petty				me (First, Middle, Lineber		Surname)	
Mary	nd 2 shoualth and N 27 Is mai er trauma		19a. Informant's Name/Relationship (Type Barbara A. Lowe, I	*			and Number or R				Code)
more,	Pages 1 a nent of He int: If item iry or othe		20a. Method of Disposition  XX Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State 20b. P	lace of Disposemetery, crem	sition (Name of natory or other plan Lvet Ceme	etery Jul	y 30, 20		cation - City or To Frederi	
Balti	permit. Departr Imports any inju		21. Signature of Juneran Service License	e/ M0025	55 Ke	Name and Address eney and 06 East C	l Basford Church St	PA Fune Frede	ral rick	Home	701
	Physician		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the death e cause on each line.	. Do not ente	er the mode of dyi	ng, such as cardia	c or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Medical bull Medical bull Medical bull Medical bull Medical street was the private transit street bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medical bull Medica	edical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of t	uence of):						
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♣ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of d 9 □ Unknown	death 3	Ectopic pregnand	гу		2	23d. Date of delive Month	ery Day Year
ds, P	luires that n signed by Ild be deta	by	Part II. Other significant conditions con	tributing to death but not resu	_		ven in Part I.				ne cause of death?
Vital Records,	sician: The law requir certificate has been s irector, page 2 should	Completed						24a. Was autop perfor 1 □ Yes	sy rmed?	24b. Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of 2 No
Vita	sician: certific rector,	å	25. Was case referred to medical examiner?  1 ☐ Yes 2 ♠ No	ospital:	55/0	oth		ath (Check only o			
Division of	ing Phy After this uneral d	tion: To	27. Manner of Death  1 ♣Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Inju Wor	ner: 4 □ Nursing I ry at k? IYes 2 □ No	28d. Describe h			(y)
Divisi	To the Hospital or Attending Physician: within 24 hours after death as a fire death. To the Funeral Director: After this certified completely filled in by the funeral director, to	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		eet, factory, office		28f. Location (S City or Tow	Street and vn, State,	d Number or Rura )	al Route Number,
	he Hospit in 24 hour ne Funera pletely fille	Medical (		ciclan: To the best of my knower: On the basis of examina and manner stated.							
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		(	30. Name and address of person who con	mpleted cause of death (Item	23a) (Type I	Print)	14620		Jul	Ly 27, 20	JU <b>Y</b>
			Pa Trav.	505 501	wy	13 50	Fred	10-165	m	0 2	170/
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24722 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Martha Minerva Hull 2009 2150 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Hagerstown Washington 8. Date of Birth (Month, Day, Year) May 20,1913 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. Months Days Hours 217-32-7184 96 Yrs MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f shovevent, the Medical Examination nust be notified as Director 1 √ Yes 2 □ No Washington Hancock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 133 West Main Street 21750 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 XNo Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 📉 No Specify. þ Specify: 3 XWidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home is marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event ones. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harvey Gladhill Nancy Cassidy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen McCarty/Daughter 604 Black Oak Road Warfordsburg, PA 17267 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Orchard Ridge Cemetery 07/23/09 Hancock, MD 22. Name and Address of Facility 141 West Main Street 21. Sonatur of Funecal Cervice Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Atrial disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** and is myopall Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physiclan; The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Year Day 5 ☐ Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed 2 🗆 No 1 □ Yes 2/2/No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1,☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending death. investigation 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after deat Funeral Director; filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number

State Registrar FA-RID (
31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

			1 - For State Registrar	State	of Mary		artment of I <i>rtificate of</i>		nd Mental Hy	giene Reg. No. 2	009	247	23
			1. Decedent's Name (First, Middle	, Last)					2. Date of De			3. Time of De	eath
	Physici /Medio		Jerome	Everet	t		Jackson		Month 7	Day 17	Year 2009	5:25	Ам
	Examin		4a. Facility Name (If not institution				4b. City, Town, o	or Location of D	Death		nty of Death	3.25	
			325 Wyman Drive				Salisb	ury		Wice	omico		
	Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days		Hrs. 8. Date of Bi	rth	9. Birthp Coun	lace (State or F	Foreign
	Director		217-10-3809	1 <b>X</b> M 2□ F	9	93 Yrs.	Months Days	Hours	9-22-	1915		yland	
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	aryla shov	'n	10a. State 10b. County		100	c. City, Town or Lo	cation				11	Od. Inside City	
	8a-f	Director	MD Wicomi	СО		Salis						1 <b>X</b> Yes 2	
	ith th	Ë	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Coun	try?	
	s 23e	ral	325 Wyman Driv					804			USA		
	er de	Funeral	11. Marital Status	12. Was Dec			Vas Decedent of F fYes, specify Cub	Hispanic Origin an, Mexican, P	r? (Specify Yes or No Puerto Rican, etc.)		Race - Americ Black, White, e		
36	within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28a-f show m Madical Exercitation to notified at	by F	1 ☐ Never Married 2 ☐ Marri 3 🔯 Widowed 4 ☐ Divorced	ed IANTES If Yes, G Year or	live	1946	□Yes 2X No	Specify:		Spe	city: Wh	ite	
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	e dea	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time		Other (specify)	., 			Month	Day Yea	ar
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	IVA		30. Name and address of person v	no completed cau	se of death	(item 23a) (Type, F	rint)	= /	11 57	. 5	1. 1		115
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	1	For State Registrar				•	tificate of L			Reg	g. No. 2	009	2472
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Examiner	1	-	-	re street and number		,	4b. City, Town, or		eatn		4c. County of Death  MONTGOMERY		
		NATIONAL         NAVAL         MEDICAL         CENTE           5. Social Security Number         6. Sex         7. Age (In yrs. la.           215-30-1734         1 M 2 □ F         7. T					re last hirthday) If Under 1 Year   If Under 24 Hrs.   8 Date of Birth						MERY place (State or Foreign intry)
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<u> </u>		3 X Widowed	1 Divorced	If Yes, Give Year or Dates	1956-7	7	I∐Yes 2⊠No	Specity:			Specify	y: W:	hite
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	-	4 ☐ Donation  21. Signature of Fu	5 Other (Special		Rid		Cemetery						Maryland
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í.	1	23a Part1. En er th	e disease, or com	plications that cause	ed the death.								
	1	shock, or hear Immediate Cause (	t failure. List only	one cause on each	line.			9,		,	,		Approximate Interval Between Onset and Death
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l'ue		23b. Was decedent in the past 12		23c. If yes, outcom  1 Live birth		eath 3	Ectopic pregnancy	,			1	ate of deliventh	very Day Year
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Physician/Medical			cant conditions	contributing to death	hut not resulti	ng in the :	nderlying cause give	en in Part I	29	e. Did toba	acco use con	tribute to	the cause of death?
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				completed cause of	death (Item 2	3a) (Type,			AL NAV			CENT	ER
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/Medica Examine		4a. Facility Name (If	AA i	1 6	end number)	25		4b. City, Town, o	aP	lata		40		irle	
Funeral Director		5. Social Security No. 579-34-0 Usual Residence of	464	6. Sex 1 [X] M 2 □		e (In yrs. las 79	st <i>birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Und Hour	der 24 Hrs. s Min.	8. Date of B (Month, I May	irth Day, Year, <b>6</b> , 1	930 W	Birthpla Count asn:	ace (State or Foreign ry) ington DC
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th with the 23a or 28 at be not	ral Dire	10e. Street and Num		nt Roa	d			10f. Zip Code 20662	<u> </u>			10g. C	itizen of What	t Count	ry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if filem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evertirist must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Marrie 3 □ Widowed		ed Armo	Decedent I ed Forces? Yes 2 X s, Give or Dates:		l li	Vas Decedent of fYes, specify Cub □Yes 2 ☑ No	an, Mexi	can, Puerto	ecify Yes or N Rican, etc.)	10-	14. Race - A Black, W Specify:		tc.
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12 should th and Mer 7 is marke traumatic	은	Launzie  19a. Informant's Na  Joyce Ann	ame/Relations	nip (Type. Prini				g Address (Stree Smith Po	t and Nu	mber or Rur		ber, City	or Town, Sta	te, Zip	Code)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 07 Day 25 **Physician** 09 A M 1135 Roger Leo Kunkle /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** WMHS BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 □ F **Director** 214-32-3752 73 29,1935 Cresaptown, MD Sept. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Allegany Rawlings 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 15230 Biers Lane 21557 Funeral <u>USA</u> 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 🗓 No Specify: ş 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Tire Manufacturing 12 should be filed w h and Mental Hygiei is marked other th <u> Tire\_Builder</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert R. Kunkle ဂ Eliza R. Hardinger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) t and 2 s Health an permit. Pages 1 and : Department of Health Important: If item 27 any injury or other tr Judith A. Kunkle/Wife <u> 15230 Biers Lane Rawlings, MD</u> 21557 Date 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 2009 4 ☐ Donation 5 ☐ Other (Specify) The Cumberland Crematory Cumberland, MD 22. Name and Address of Facility Smith Funeral Home 85 S. Main Street Keyser, WV Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ravs disease or condition resulting in death) 0 Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last iner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Exami Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal deat 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the a d be detached for 1 □Yes 2 □No Ö 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed certificate 1 Yes 2 No 1 ☐ Yes 2 1No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) 1 Inpatient 2 ER/Outpatient 3 DOA မှ this funeral ( 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred spital or Attending P nours after death. neral Director: After i y filled in by the funera After Certification: Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital 24 hours a ical within 2.

> State Registrar

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DHMH 17 Rev 1/2001

29a. Certifier

(Check only one)

29b. Signature and title of certifier

and manner stated.

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

LAVALE MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 11:20a M 2009 July Florence L. Lidie 15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4990 Flossie Avenue Frederick Frederick If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🖾 F Director 219-20-0964 82 Sept.28,1926 Maryland Usual Residence of Decedent be filed within 72 hours after death with the Maryland ntal Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 21 No Director Maryland | Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4990 Flossie Avenue 21703 Funeral United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No Specify: Completed by Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be fi Department of Health and Mental H Important: If Item 27 is marked of any injury or other traumatic even once. ٩ Martin Gray Grace Phelps 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter Gayle L. Frushour/ 4823 Mt. Zion Road, Frederick, Maryland 21703 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 St Burial 2 ☐ Cremation 3 ☐ Removal from State 7/20/2009 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Memorial Gardens Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on- or use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Tyn **Physician** WYC /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1∐Yes 2∭XNo 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this ( Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation I Director Af o in by the fur 2 Accident М 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a time Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifia 29c. License number 29d. Date signed (Month, Day, Year) 7-15-09 765 30. Name an Address of Person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Tourn 32. Registral's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) July Day  $200^{\text{Year}}_{9}$ 25, 8:34 AM Ruth Gertrude Miller 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Caroline Denton Caroline Nursing Home If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1□M 2€X 209-12-0832 86 1922 Pennsylvania July 26, Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1X Yes 2 No Caroline Denton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21629 520 Kerr Avenue 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 🕅 No 1 Never Married 2 Married White 1 Yes 2 No 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Home Domestic Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Matilda Truitt William Barney Truitt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 110A S. Main Street, Greensboro, MD 21639 William J. Miller/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Mid-Shore Crem. Ctr. 07/27/09 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Framptom Funeral Home, 216 N. Main St., Federalsburg, MD 21632 21. Signature of Funeral Service Licenses Michael 7 Iskow 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) COSONONY a-tery Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1☐ Yes 2☐ No 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Man of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

/Medical **Examiner** To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

"natural", or Items 23a or 28a-f shov edical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or Item any Injury or other traumatic event, the Medical Examiner once.

**Physician** 

Baltimore, Maryland 21215-0036

Director

Completed by Funeral

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death with the Maryland

Examine Physician/Medical ģ Completed Be မ Certification:

29a. Certifier

(Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier CM

0005325

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Avenue Preston MD 21655 Bu Lednum

State Registrar

Medical

31. Date filed (Month, D

strar's Signature

		For State Registrar	State of Maryland		rtment of Hea tificate of De		ental Hygie Reg.	4000	24729
Physic		1. Decedent's Name (First, Middle, Last	anning MacKni	aht.			2. Date of Death Month July 2:	Day Year 3 2009	3. Time of Death
/Medi Examii Funeral Director		4a. Facility Name (If not institution, give  Homestead Manon  5. Social Security Number  6. Se	street and number)			Under 24 Hrs.	8. Date of Birth (Month, Day, Ye March 12, 1	4c. County of Death  Carolir 9. Birth Cor	1
land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits
e Mary ta-f sho	ctor	Maryland Carol	line D	enton					1 Yes 2 No
with th	Dire	10e. Street and Number			10f. Zip Code 21629			Citizen of What Co	untry? es of America
BAITIMORE, IMARYIBING Z I Z I 3-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If item 27 is marked other then "netural", or Items 23a or 28a-1 show eny injury or other treumatic event, it e Medical Evertical must be rotified at eny pince.	by Funeral Director	1040 North Heritag  11. Marital Status  1 Never Married 3 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		/as Decedent of Hispa Yes, specify Cuban, N	anic Origin? (Spe Mexican, Puerto F Specify:		14. Race - Ame Black, White	ncan Indian,
D-UU.	eted b	15. Decedent's Edu (Specify only highest grad		(Give I	ent's Usual Occupation	n ng most of workir	161	o. Kind of Business/	
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Maryland nd 2 should be file th and Mental Hy 27 Is marked oth	Be	17. Father's Name (First, Middle, Last)  William	Mack	night	18		(First, Middle, Mai Jaret	den Sumame) Davidsoi	2
aryta arfyta and Men s marka	2	19a. Informant's Name/Relationship (7)	ype, Print)	19b. Mailin	g Address (Street and	Number or Rura	l Route Number, C	ity or Town, State, Z	lip Code)
C, Mis		Dorothy Hershey  20a. Method of Disposition	3		Rolling Hi. lition (Name of atory or other place)			c. Location - City or	Pennsylvani Town, Slate
Baltimore, permit. Pages 1 a Department of Hes Importent: If item eny injury or otha		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify,	Removal from State		atory`or other place) emutory	7/24/2		xer, Delawar	
<b>BAILING</b> permit. Page Department of Importent: If eny injury or once.		21. Signature of Funeral Service Licens	More	12	Name and Address of South Second	Home, P.A. L Street,	Denton, Ma	ryland 2162	9
Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of limediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to for a a conseque	acumence of:	te reno	1 fail			Approximate Interval Between Onset and Death
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luires that n signed build be deta	þ	Part II. Other significant conditions co	ontributing to death but not result	ting in the ur	derlying cause given i	in Part I.			the cause of death?
II KECOTCI: The law require cate has been single 2 should I	Completed						24a. Was an autopsy performe	d? prior to death?	ntopsy findings available completion of cause of
On Of VITE  Jing Physicien  After this certifit  tuneral director	To Be	27. Manne of Death  1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	R/Outpatien 28b. Time of Injury	Other: 28c. Injury at Work?	4 Nursing Hor	28d. Describe how		3
DIVISIC  To the Hospital or Attent within 24 hours after deatt To the Funerel Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ural Route Number,
Hospital or 24 hours afte funerel Dir	edical	29a. Certifier 1 ☐ Certifying Phy (Check only 2 ☐ Medical Examone)	ysician: To the best of my know iner: On the basis of examination and manner stated.	rledge, death on and/or inv	occurred at the time, estigation, in my opini	date and place, a ion, death occurr	and due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
To th within To th	Me	29b. Signature and title of certifier		MO	29c. License n	umber 53a		Date signed (Mont	h, Day, Year)
		30. Name and address of person who de the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second se	completed cause of death (Item	23a) (Type.			}	2165	5
Si Regis	ate trar	31. Date filed (Month, Day, Year)	9 P. Registrar's Signar		red .				

		State of Maryland / Dep	partment of He ertificate of D		Mental Hygie	000	9 24731
B1		1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
Physici /Medic		Gary Thomas Mattox			July 23		1:00 P M
Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Lo	ocation of Death		4c. County of De	ath
		31125 Covey's Landing Road  5. Social Security Number   6. Sex   7. Age (In yrs. last birthda	Cordova	a. If Under 24 Hrs.	8. Date of Birth	Talbot	irthplace (State or Foreign
Funeral Director		1 □ M 2 □ F CO Yrs	Months Days	Hours Min.	Month, Day, You January 15,	éa <i>r)</i> (	rth Carolina
		217-36-1534			January 13,	1940   110	th Carolina
Mot #		10a. State 10b. County 10c. City, Town or	Location				10d. Inside City Limits
s-f.s	tot	Maryland Talbot Cordo	ova				1 ☐ Yes 2 No
illed within 7.2 flouts after beauth with the marylating Hygiene. Hygiene. Wher than "natural", or items 23a or 28a-f show ent, it confeder Examination must be notified.	Directo	10e. Street and Number	10f. Zip Code			. Citizen of What C	
23a		31125 Covey's Landing Road	21625	<u> </u>	Un	ited Stat	es of Ameri
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Medical Examiner must be notified at once.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	<ol><li>Was Decedent of Hisp If Yes, specify Cuban,</li></ol>	panic Origin? (Sp , Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	nerican Indian, ite, etc.
or i	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give	1 □Yes 2 🛣No	Specify:		Specify: Ca	aucasian
ural.		3 ☐ Widowed 4 ☐ XDivorced Year or Dates:	cedent's Usual Occupati	ion	16	b. Kind of Busines	
"na"	Completed	(Specify only highest grade completed) (Gir	ive kind of work done du e. DO NOT use retired)	ring most of work	ing	b. Ring of Eddinos	o made i y
iene.	Ē	Elementary/Secondary (U-12)   College (1-40r 5+)	Fitter/Wel			ndustrial	l Constructi
thyg other ent,	Be C	17. Father's Name (First, Middle, Last)	1	8. Mother's Nam	e (First, Middle, Ma	iden Surname)	
ked ked ic ev	To B	Thomas Jefferson Mattox		Mary	Pauline	F1ynn	
and Mental	-	19a. Informant's Name/Relationship (Type. Print) 19b. Ma	ailing Address (Street an	nd Number or Ru	ral Route Number, C	City or Town, State	, Zip Code)
Health a tem 27 is		Michael G. Mattox Son PO	Box 387, Qu	ieen Ann	e, Maryla	nd 21657	7
item othe		20a. Method of Disposition 20b. Place of Dis	sposition (Name of rematory or other place)		Date 20	c. Location - City of	or Town, State
nent of int: If its iry or o			unt Cemeter		/2009 H	illsboro	, Maryland
partn sorta / inju		21. Sign v re of Funeral Service Licenses	22. Name and Address	of Facility		-	
Depar Impor any ir			loore Funera 2 South Sec			on Marv	land 21629
		23a. Part 1. Enter the disease, or complications that caused the death. Do not e	enter the mode of dying,	, such as cardiac	or respiratory arres	t,	Approximate
hysician		Immediate Cause (Final	Arcietios	e P	(monox)	disease	Onset and Death
/Medical		Immediate Cause (final disease or condition resulting in death)  Sequentially list conditions  ATTIME  Due to (or as a consequence of):	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	- 70	7	0,7000	
xaminer		ATTINI	1/utter				1 month
	je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
nd ransi	Examine	that initiated events C.					
ian a		resulting in death) Last Due to (or as a consequence of):					
hysic the bi	Physician/Medical	d					
ling p	Mec	IF FEMALE:					
ittend or us	ian/	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy	3 Ectopic pregnancy			23d. Date of o	delivery Day Year
the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	5 Other (specify)				,
ed by letacl	Ph)	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given	n in Part I	23e. Did toba	cco use contribute	to the cause of death?
signe I be c	b	Tarring of the Significant contained to containing to country but not recording in the	s and onlying cause given				Probably 4 ☐ Unknow
hould	Completed						<u>i</u>
has b e 2 s	혈				24a. Was an autopsy performe	prior t	autopsy findings availabl to completion of cause of
icate ; pag	Ŝ				1 □Yes 2		
sertifi ector	Be	25. Was case referred to medical examiner?			th (Check only one)		
this al dir	은	1   Tes 2   FR/Outpat		4 LI Nursing H	ome 5 Residen		pecify)
After After funer	<u></u>	Natural 5 Pending (Month, Day, Year) Injury	y Work?		28d. Describe how	injury occurred	
tor:	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 288 Place of Injury - At home farm		es 2 No	29f Location (Stro	at and Number or	Pural Pauta Number
Direction by	Certification:	4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide	street, factory, office		City or Town,	State)	Rural Route Number,
eral eral filled		20a Cartifier Destifying Physician: To the best of my knowledge de	nath occurred at the time	a data and place	and due to the car	sea(e) and manner	as stated
24 hc Fun etely	Medical	29a. Certifier (Check only one)  2□ Medical Examiner: On the basis of examination and/or and manner stated.					
within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Mec	29b. Signature and title of certifier	29c. License	number	290	d. Date signed (Mo	onth, Day, Year)
3 ₹ 8		in go MD		5/132		72%.	
		CO. Name and address of passes who granted arrives of death (the CO.) (To.)				, ,	1
		30. Name and address of person who completed cause of death (Item 23a) (Typ		M 7	1 01603	1	
Sta	ate	Jorge Abrego, M.D., 598 Cynwood Dr.	rve, <u>Laston</u>	., Maryla	ing 2160		
Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Was -				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death  $2\overset{\mathsf{Day}}{2}$ Physician 2009 8:20 P M Ju1y Michael Jay Moore /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Talbot Easton Memorial Hospital If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, Funeral Year) 1/2 M 2□ F 45 July31, Maryland 219-86-0401 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10a. State 10h County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating the notified at 1X Yes 2 No Director Maryland Caroline Ridgely 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 4 Seward Road 21660 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 M No 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Š If Yes, Give Year or Dates: Specify. 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) truck driver propane 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Shirley Lane Moore William J. Moore ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ridgely, Maryland 21660 PO Box 52; Shirley L. Moore/ mother Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 \( \) Burial 2 \( \) Cremation 3 \( \) Removal from State 4 \( \) Donation 5 \( \) Other (Specify) July 27 2009 Ridgely, Maryland Ridgely Cemetery 22. Name and Address of Facility
Fleegle and Helfenbein Funeral Home, PA
PO Box 160; Greensboro, MD 21639 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ending physician and use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) signed by the a 1 □ Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ⋧ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown To the Hospital or Attending Physician: The law requir within 24 hours after death.
To the Funeral Director: After this certificate has been sompletely filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? Syndhina. Was an 015 Mess autopsy performed? res 2. No Hypoteusion 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

219 South Washington Street,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** July 14, 2009 12:45AM DOROTHY R. MARR /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Manor Care Wheaton Wheaton Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 92 2/12/1 Director 214-30-3705 MD Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No **Funeral Director** MD Montgomery Wheaton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò 2104 Shorefield Rd. U.S.A. 20902 items 23a 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Deceuci.. \_ Armed Forces? 1 □Yes 2 No Black, White, etc 1 Never Married 2 Married ò If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify. Completed by Black 3 Widowed 4 Divorced "naturaf" 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Home permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy, Important: If item 27 is marked other any injury or other traumous. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Marr Mary Barnes ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Marr - brother 1312 Nicholson St, Hyattsville, MD 20782 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation Lingolh Mem. Cem. 7/22/09 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Snowden Funeral Home, P.A. Funeral Service Licens 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** Third degree heart block disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Tuneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of). Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 🗷 No 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Hypertension autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier † Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title D58962 7/16/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shashank Gnyanesh Patel, 18121 Georgia Ave, Olney, MD 20832 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

of Vital

Division

			For State Registrar		State of Ma	iryiand		artment of rtificate of	Health and I Death	мептат ну	Reg. No.	009	24733
	Physicia	an	1. Decedent's Name  Fdn G	(First, Middle, Las	1	CDO	nal	0		2. Date of De Month	Day	Year 2009	3. Time of Death
	/Medic Examin		4a. Facility Name (If	not institution, give	street and number)		1	4b. City, Town,	or Location of Death	1	/	nty of Death	
	Funeral Director		5. Social Security Nu 220-05-50	ımber 6. Se	nty Colonel X 1 7. Age JM 25xF	(In yrs. lasi 91	t birthday) Yrs.	If Under 1 Year Months Days					
	D		Usual Residence of 10a. State			10c. City, 1	Town or Lo	cation				1	0d. Inside City Limits
	Maryla i-f sho	to		Howard			cott						1 ☐ Yes 2 X No
	or 28a	Director	10e. Street and Num					10f. Zip Code				of What Cour	itry?
	s 23a	eral [	4009 High	Point R	12. Was Decedent E	Summin III D	140.1	21042	Historia Origin? (S	posity Vos or Ne	USA	Race - Americ	ean Indian
036	172 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Examinational be notified at	by Funeral	<ul><li>11. Marital Status</li><li>1 ☐ Never Marrie</li><li>3 ☐ Widowed</li></ul>		Armed Forces?  1  Yes 2 N  If Yes, Give Year or Dates:			if Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puert Specify:	o Rican, etc.)		Black, White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or White, or	etc.
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	e filed within al Hygiene. other than " ent, the We		17. Father's Name (	First Middle Last)	4		Accou	ıntant	18. Mother's Nan	ne (First. Middle		nting name)	
and	be d all be	To Be	Walter Li						Hollis		,	,	
Maryland 2	12 sho h and 7 is m traum		19a. Informant's Na Betty Cur		ype. Print) / Daughter				et and Number or Ru int Rd., I				
altimore,	of it				Removal from State	cerr	netery, cřer st La		Gdns. 7/2		Marr		ille, MD
Balti	permit. Page Department of Important: If any Injury or once.		21. Signatur of Fu	the			41	12 Old (	Columbia I	Pike, El	licott		mily FH, Inc MD 21043
	Physician		shock, or heal immediate Cause ( disease or condition	rt failure. List only o Final	elications that caused one cause on each in	the death. MULN		1	ying, such as cardiad	c or respiratory	arrest,		Approximate Interval Between Onset and Death IS Cluye
	/Medical Examiner		resulting in death)		Due to (or as	a consequer	nce of):	io he	at Fa	ilura	2.		3 months
	is te	niner	Sequentially list cor if any, leading to im- cause. Enter Under Cause (Disease or	nditions, mediate rlying	Due to (or as								
60,	icate be executed physician and the burial-trans t	al Examiner	that initiated events resulting in death) L		CDue to (or as a	a conseque	nce of):		; <del>,,</del>				
68760	tificate g phys as the	edical			d								
O. Box	The law requires that the death certificate be execute ate has been signed by the attending physician and bage 2 should be detached for use as the burial-frans	Physician/M	IF FEMALE:  23b. Was decedent in the past 12  1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal d	eath 3	⊒Ectopic pregna ⊒Other (specify)			23d.	Date of deliv Month	ery Day Year
σ.	ires that th signed by d be detach	ρ		icant conditions	ontributing to death bu	ut not resulti	ng in the u	nderlying cause	given in Part I.		tobacco use o		he cause of death? bably 4 ☐ Unknown
Vital Records,	sician: The law requir s certificate has been s irector, page 2 should	Completed				_				per	opsy formed?	prior to co death?	opsy findings available impletion of cause of
Ita	ian: T ertificat ctor, pe	Be Co	25. Was case refer	red to medical					26. Place of Dea		2 ⊠No one)	1 ☐ Yes	2 LINO
	ng Phy (fter this ineral d		examiner? 1 ☐ Yes 2 ☑  27. Manner of Deat		Hospital: 1 Inpatie 28a. Date of Inju (Month, Da)	ry 2	R/Outpatie 8b. Time o Injury	of 28c. In	jury at ork?	Home 5 ☐ Res 28d. Describe	how injury oc		fy)
Division of	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Certification: To	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investigation 6  Could not be determined		ury - At hom c. (Specify)	e, farm, sti		□Yes 2□No e	28f. Location City or To	(Street and Nown, State)	umber or Rur	al Route Number,
_	e Hospital 124 hours e Funeral letely filled	Medical Co	29a. Certifier (Check only one)	1∰ Certifying Ph 2☐ Medical Exam	ysician: To the best niner: On the basis o and manner sta	f examinatio	edge, deai on and/or in	th occurred at the nvestigation, in m	e time, date and plac y opinion, death occ	e, and due to th urred at the time	e cause(s) an e, date and pla	d manner as ace, and due t	stated. to the cause(s)
	To th within To the compl	Me	29b. Signature and	title of certifier	-//	7		29c. Lice	ense number	,	,	igned (Month,	-
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(	(P) 12-		30. Name an addr	n! Zun	ompleted cause of d	405	Fred	Print) LUZK R	d Quit	Orsville	1 MID	212	28
	Sta Registi		31. Date filed (Mon	JOL 21 2	009 32. legistra	ar's Signatu	ie. 1	arkel					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 15, Day 2009 Year **Physician** 6:09 P M Κ. Marcus Mary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 01ney Montgomery Montgomery General Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth 6. Sex **Funeral** 1□ M 2 F Months Days Hours Maryland December 579-40-1190 102 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location It than "natural", or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, the Modical Examiner must be notified a MD Montgomery Silver Spring 1 Yes 2 No Completed by Funeral Director 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 20906 United States 15100 Interlachen Drive #217 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 □Yes 2 XNo Specify 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Government Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Morris Kirsch Dora Forman 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2893 Glenora Lane Rockville MD 20850 Roslyn S. Sandler - Daughter 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3X Removal from State 7/19/2009 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Service Licensee 22 Name and Address of Facility neral Direction Inc 1091 Rockville Pike Rockville MD 20852 M01163 Approximate
Interval Between
Onset and Death

Minimal 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** LEROTIC CORONARY ATHERO /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Pregnant at time of death 5 Other (specify) 9 Unknown veral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 Tes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 □ No 1 🗌 Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and panner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert F. Larkin, MD 18101 Prince Philip Drive Olney MD 20832 31. Date filed (Month, Day, Year) 32 Registrar's Signature State backer JUL 20 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

10

Day

Year

MD

14. Race - American Indian.

Black, White, etc.

Specify: Black

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No

Year

Month

2009

 $a^{\,\text{M}}$ 

0250

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 X Yes 2 ☐ No

2. Date of Death

July

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SATYAL, MD

32 Registrar's Signatur

R

20

31. Date filed (Month, Day, Year)

1. Decedent's Name (First, Middle, Last)

Mary Ellen Milbourne

**Physician** 

/Medical

State Registrar

DHMH 17 Rev 1/2001

1604 MARKET ST

POCOMOKE CITY

09-05737

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Minh Q. Nguyen 1- For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day July 22, 2009 1041 hrs **Medical Examiner** Minh Quoc Nguyen

4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Prince George's Doctor's Community Hospital ER Lanham If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** oreign Months Davs Hours Country) Vietnam Director May, 19 1998 219-81-8107 1 X M 2 11 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Yes 2 No 28a-f shov Prince Georges Lanham notified at once. Maryland after death with the Maryland 10g, Citizen of What Country? 10f. Zip Code Direct 10e. Street and Number Vietnam 20706 8806 Spring Avenue items 23a 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc 1 X Never Married Armed Forces? Married Yes If Yes, Give Year Yes 2 X No specify: Specify: Divorced Widowed Vietnamese ð 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 72 hours inent of Health and Mental Hygiene. ant: If item 27 is marked other than "natura or other traumatic event, the Medical Exami 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Robert Frost Elem. Baltimore, MD 21215-0036 Student 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Loan Thi Te Be Duc Tan Nguyen 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8806 Spring Ave. Lanham, MD 20706 (friend) Kim Nguyen 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State Department of Important: Chesapeake Crematory July 27,2009 Beltsville, MD 5 Other Specify Donation 22. Name and Address of Facility Rendon/Hale Funeral Home 21. Signature of Funeral Service License 9013 Annapolis Rd. Lanham, MD 20706 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Myocarditis Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23a,27,perME, g894 8/10/09 TT X UNPENDED AMENDED attending physician or use as the burial The law requires that the death certificate be Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day Live birth 3 Ectopic pregnancy Month Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown ned by the atte 9 Unknown 23e. Did tobacco use contribute to the cause of death? <u>O</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>≨</u> 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed Division of Vital Records, has been si 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? certificate h ector, page No Yes 2 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Be examiner? Other; Residence 6 Nursing Home 5 Other Inpatient 2 V ER/Outpatient 3 DOA this No 2 1 ✓ Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After Manner of Death Certification: 1 X Natural Yes 2 No Pending 24 hours after death To the Funeral Director: completely filled in by the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. July 23, 2009 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD State 4 2009 Registrar **ORIGINAL** 

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of H <i>rtificate of L</i>			giene 2	009	2473
		Decedent's Name (First, Middle	e, Last)				2. Date of Dea		.,	3. Time of Death
Physicia		Martha Louise	Downo1				Month July	Day 24	Year 2009	9:55 P
/Medic		4a. Facility Name (If not institution			4b. City, Town, or	Location of Deat			unty of Death	
Examin	ier					200411011011011				
		Caroline Home 5. Social Security Number		e (In yrs. last birthday	Denton   If Under 1 Year_	If Under 24 Hrs.	8. Date of Birth	1	roline 9. Birth	place (State or Forei
uneral irector		219-56-7872	1 □ M 2 💁 F	60 Yrs.	Months Days	Hours Min.	Aug. 4,	1948	Virg	intry) inia
		Usual Residence of Decedent					<u> </u>		18.	
MOL TE		10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limit
i s	호	Maryland Carol:	ine	Greensb	oro					1A Yes 2 □ N
128	ie	10e. Street and Number		1	10f. Zip Code			10g. Citizen	of What Cou	ntry?
3a o	<u></u>	303 Bernard Ave	Α.		21639			U.S.A	Δ .	
E SE	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S	pecify Yes or No-		Race - Ameri	
er is		1 ☐ Never Married 2 ☐ Mar	ried Armed Forces?	No	1 ☐Yes 2 X No		o Ricari, etc.)		Black, White,	etc.
al",c	ğ	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 Lives 2 Louino	Specify:		Sp	ecify: Wh:	ite
ical	Completed	15. Deceden	nt's Education est grade completed)	16a. Dece	edent's Usual Occupa kind of work done o	ation	rkina	16b. Kind	of Business/Ir	ndustry
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t a	5	12		Line	worker			Poul:	try Inc	dustry
vent	Be (	17. Father's Name (First, Middle,	Last)			18. Mother's Nar	ne (First, Middle,	Maiden Sur	name)	
rrke rtic e	ျှ	Dallas Austin A	Adkins			Minnie 1	Mae Adki	ns		
S ms		19a. Informant's Name/Relations	ship (Type. Print)	19b. Mail	ing Address (Street a	and Number or R	ural Route Numbe	r, City or To	wn, State, Zi	ip Code)
er tra		James A. Ratli	Ef/Son	318	N. Main St	., Gree	nsboro,	Maryla	and 2	1639
oth		20a. Method of Disposition		20b. Place of Disp	osition (Name of matory or other place	9)	Date	20c. Locat	ion - City or T	own, State
Department or near an or water raygener. In particular, or items 23a or 28a-f show importants if the Z7 is marked other than "natural", or items Z7 is not any injury or other traumatic event, the involced Examination once.		1 Burial 2 Cremation 4 Donation 5 Other (5			ro Cemeter		28,2009	Green	sboro	, Maryland
orta Inju		21. Signature of Funeral Service			2 Name and Addres					
8 9 1		Much	Chler	~	loo W. Sur	id Helle	ndein Fu	neral	Home,	PA land 216.
		23a. Part 1. Enter the disease, or	r complications that causer	the death. Do not er					midty.	Approximate
		shock, or heart failure. List Immediate Cause (Final	t only one cause on each li	ne.	raphic L	ateral	Colo	-AP. C		Interval Between Onset and Death
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physician and the burial-transit	dical		d							
phy s the	edic		u.							
noing Le a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d	. Date of deliv	very
atte for u	cial	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a		☐ Ectopic pregnancy ☐ Other (specify)	/			Month	Day Year
y the	ıysi	1 □Yes 2 ➡No 9 □ Unknown	9 ☐ Unknown							
ed b deta		Part II. Other significant conditi	ons contributing to death b	out not resulting in the	underlying cause give	en in Part I.	23e. Did to	bacco use	contribute to	the cause of death?
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peen	Completed							1.		6-6
has e 2 s	du						24a. Was	an 2 sy med?	prior to co death?	opsy findings availa ompletion of cause
cate,	Ö						1 □Yes	2 <b>12</b> No	1 ☐ Yes	2 □No
ertifi ector,	Be	25. Was case referred to medica examiner?					ath (Check only o	ne)		
his c		1 Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatie		4 LI Nursing i	lome 5 Resid	lence 6	Other (Spec	eify)
fter t	Ë	27. Manner of Death 1 ■ Natural 5 ■ Pendir	28a. Date of Inju (Month, Da	ury 28b. Time ( ay, <i>Year)</i> Injury	of 28c. Injury Work	y at ?	28d. Describe h	ow injury o	ccurred	
or: A he fu	äţi	2 ☐ Accident investi	igation		M 1 1	Yes 2 □ No				
rection py t	Certification: To	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	nined [28e. Place of In]	ury - At home, farm, st	reet, factory, office		28f. Location (S City or Tox		lumber or Rui	ral Route Number,
al Di	Cer									
uner ly fill			ng Physician: To the best Examiner: On the basis of							
To the Fundan all prector. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for u: e as	Medical	one)	and manner st	ated.	nvestigation, in my o	death occ	arrea at the time,	date and pr		to the cause(s)
To t	Σ	29b. Signature and title of certifie	H MI		29c. License	e number	_	29d. Date s	igned (Month	, Day, Year)
		) Hotel	N		1 by h	748		71	7810	19
		30. Name and address of person			, Print)			_,	10.0 N	21601
		Peter Whil	tesell mi	D 5051	4 Dutch	man's	Ln K	arton	'WD	21601
		Od Date Elad (Manth Day Voor	32. Régistr	rar's Signature	1 11					
Sta	ite	31. Date filed (Month, Day, Year)	0 0000	aram / Al-	1956 W					

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Amend Item II per Spouse 1900 2719 All Gopies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 1 9

Amend Item II per inf C900 2/24/10 dk

Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** DOUGLAS AUGUSTUS PUMPHREY 2009 10:23PM 14, July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Village Montgomery 18743 Walkers Choice Rd. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days ₩ M 2 F Yrs. 220-28-7168 74 DC 8/23/34 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 □ No Montgomery Village Director MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with intent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or:
ury or other traumatic event, the Modical Examinar must be no 20886 U.S.A. 18743 Walkers Choice Rd. Funeral 11. Marital Status X Divorcd .12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 ½ No If Yes, Give Year or Dates: 1 Never Married - Married 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Public School Custodial Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Beatrice Holland Herbert Pumphrey ဂ္ 20904 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type. Print) Hattie Mae Watts-daughter2128 Harlequin Terr., Silver Spring, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1X Buria ☐ Cremation 3 Remova 7/22/09 Silver Spring, MD 5 ☐ Other (Specify) 22. Name and Address of Facility Snowden Funeral Home, P.A. 21. Signature of Funeral Service 246 N. Washington St, Rockville, MD 20850 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failule. List only one cause on each line. o not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Intection sepsis /Medical Due to (or as a consequence of) Examiner Cardio Pulmonary Arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by Stroke, chronic kidney disease, anemia 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 2 No 1 ☐Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA PICE Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred Injury at Work? 1 X Natural 5 Pending 1 ☐Yes 2 ☐No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specity) 4 Homicide 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only manner stated

Box 68760. Ö σ. Division of Vital Records, Hospital or Attending Physician: To the Hospital or Attend within 24 hours after death To the Funeral Director:

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Martin Arquimedes Portillo,

29d. Date signed (Month, Day, Year)

501 N. Frederick Rd, Gaithersburg,

20876

09-05453 Tyler Maurice Polk

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 24739

			1- For				Cert	ificate of	Death_				Reg.	No.		3. Time of Death
Phy	ysicia		Regist 1. De	trar cedent's Name (First, Middl	e,Last)							_ N	Date of Death Month D	ay Ye		0839 hrs
dical Ex	xamin			yler Mauri		olk							uly 12, 200		of Death	00001110
3			4a. Fa	acility Name (if not institution	n, give str	eet and nur	mber)		b. City, Town			eath		4c. County		
			S	outhbound US Rt. 13	3 south	of Stewa	irt Neck Road	d	Princess	Anne	•			1		-1- (Otata as Familia)
<b></b>		-		cial Security Number	6. Sex		7. Age (In yrs. la		If Under 1	_	If Under 2		. Date of Birth (	MM/DD/YYY	Y) 9. Birth Cou	nplace (State or Foreign ntry)
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Dile	CLOI	١		9-25-6206	1 _ XM	2F	24									
	>	- 1		Residence of Decedent State 10b. County			10c. City,	Town or Location	on							10d. Inside City Limits
	w an		IVa.													1 X Yes 2 No
and	Sho	5		ID Wico	micc		Sal	isbury	10f. Zip Co	de			100	. Citizen of \	What Coun	try?
Manyl	28a-	Director	10e.	Street and Number												
the	ns 23a or 28a-f show any be notified at once.		72	2 B Rivers	ide	Road	l		218	01		0 / 5000		S.A.	ce - Ameri	can Indian, Black,
with	1s 23	Funeral	11. N	Marital Status	1	<ol><li>Was Dec Armed F</li></ol>	cedent Ever in U.	S. 13. Wa	s Decedent o es, specify C	of Hispa Cuban, N	ınıc Origin Mexican, F	uerto Ric	fy Yes or No- can, etc.)		nite, etc.	
eath	is is	E .	1 <u>X</u>	Never Married 2		Yes	2 X No	1						Specif	Blac	k
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urs a	amir	d by	15.	. Decedent's Education (Sp	ecify only	highest gra	de completed)	16a. Deceder	it's Usual Oc- ost of workin	cupation g life. D	n (Give kii OO NDT u	na of wor se retired			Dasii looor	
2 ho	"na	Completed	Е	lementary/Secondary (0-12	)	College (	1-4 or 5+)							Dish	1	
36 hin 7	than edica	ğ	·l	12th	ì			Inst	aller				irst, Middle, M	Netwo		119
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician July 24,2009 Gary Phipps 1:30A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Center Lorian Nursing&Rehabilitation Taneytown Carroll 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Social Security Number Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F 216-70-2894 **Director** May16,1955 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Carroll Westminster 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 908 Old Westminster Pike 21157 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Construction Heavy Equipment Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be es 1 and 2 should be fill of Health and Mental Hitem 27 is marked other Edith Earlean Witt Louis A. Phipps, Sr. other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Thea Phipps 908 Old Westminster Pike, Westminster, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 permit. Pages Department of I Important: If ite any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) OuestAnatomical7-24-09 White Hall, PA. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 6009Harford Road, Baltimore, Maryland21214 23a. Part1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off burial-tran and Due to (or as a consequence of) Box 68760. the attending physician death certificate be Physician/Medical the as IF FEMALE: use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ē Month Day Year 5 ☐ Other (specify) 0 ☐Yes 2☐No detached 9 Unknown 9 I Inknown ۵. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ pe 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A
completely filled in by the fi 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Kertifylng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 39. Name and address of person who completed cause of death (Item 23a) (Type, Print) mp 333 32. Registrar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

# BARBARA OCHA,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 10:33 PM **Physician** 2009 JULY Kocha arbara /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CHARLES MEDICAL CENTER A PLATA CIVISTA Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F Brazil 12/4/1926 Director 577-70-1252 82 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinal mant to notified at 1 Yes 2 No Director Prince George's Waldorf Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with USA 20602 3252 Guilford Drive Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: Black <u>ک</u> 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the Mental Other. Elementary/Secondary (0-12) College (1-4or 5+) Private Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vitalina De Silva ည John De Oliva Roche 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3252 Guilford Drive Waldorf, Maryland 20602 Juanita V. Thomas / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/23/2009 Triangle, VA 4 Donation 5 Other (Specify) Quantico National 22. Name and Address of FacilitAlexander S. Pope Funeral Home 21. Signature of Funeral Service Licensee Ave. SE Washington, D.C. 20020 2617 Penn. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) ATTIME IN Physician /Medical e to (or as aconsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): (Jzrosc Hospital or Attending Physician; The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending p for use as 1 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 5 Other (specify) vate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □ Yes 2 2 🗆 No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 27 NO 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

le Funeral Director: A
bletely filled in by the fu 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier within 24 ho

To the Fune

completely 1 and manner stated 29d. Date signed (Month, Day, Licease number 29b. Signature and title of certifier 31. Date filed (Month, Day, Year, JUL 2 1 2009 State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend I tem 26 per phys. 6894 873469 All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 8:30 Рм 23 2009 Mary Evelyn Shoop /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Worcester 108 Newport Bay Dr. Unit B Ocean City If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🖺 F 94 220-03-9951 June 12, 1915 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "national Examinar must be retified at 1 XYes 2 ☐ No Fredericksburg Director Virginia 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 22401 209 Wilderness Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 🔯 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🔀 No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify. ģ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edgar Lewis Dietrich Mary Viola Johnson ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Son: William Shoop, Jr. 108 Newport Bay Drive Unit B Ocean City, MD 21842 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sunset Memorial 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State July 30, 2009 Fredericksburg, VA 4 ☐ Donation 5 ☐ Other (Specify) Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 Williams St. Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardio Vascular Hy heroscleratic Immediate Cause (Final **Physician** curs disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the burial-trar resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical attending p as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year signed by the a 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 s certificate 1 ☐Yes 2 ☐No 1 ☐ Yes or Attending Physician: ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Residence 6 Other (Specifyresidence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 28769 person who completed cause of death (Item 23a) (Type, Print) contaltyhua, Ferunck Island, De 19944 Wholes Dorodulia

DIC

8

State
Registrar

31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 200 oroth. /Medical County of Deat City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner dica Glen TUNE JURNIE RUNGE ItIMORE ENTER Birthplace (State or Foreign Country) Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 26 f Under 1 Year 7. Age (In yrs. last birthday, **Funeral** Months Days Hours Min. 1 □ M 2 🗓 F 1965 Maryland 214-96-0646 44 **Director** Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10c. City, Town or Location ortant: if item 27 is marked other than "natural"; or items 23a or 28a-f show injury or other traumatic event, the Medical Exal instructs the notified at 1 ☐ Yes 2 X No Director Anne Arundel Maryland Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with USA 123 Sunlight Court 21061 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 📉 No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married and 21215-0036 1 ☐ Yes 2 X No If Yes, Give Year or Dates Specify Specify: White ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) own home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental ant: If item 27 Is marked o Sharon Griffey Michaels Percy Aisquith ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau 123 Sunlight Court; Glen Burnie, MD 21061 Michael Smith/ husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State July 22 2009 Greensboro, Maryland Greensboro Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Home, PA Fleegle and Helfenbein Funeral TO Box 160; Greensboro, MD 216 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final METASIAIC BR CHOST **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of P.O. Box 68760. attending physician Physician/Medical the Se 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day for in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No the 9 Unknown 9 I Inknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? performe 1 ☐ Yes 2 ☐ No certificate 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 🗹 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deat Funeral Director: filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) completely and manner stated within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 0055703 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gur Buzzit mil 100, CAL SALTMONE WAS インとしい Cenn strar's Signature 31. Date filed (Month, Day State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009 **Physician** 2:09 A M July 16, MAXINE S. SROLE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montogmery Rockville Shady Grove Adventist Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 02/02/1949 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 F 60 Washington DC Director 216-46-4153 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lighty or other traumatic event, the Modical Exprinter must be notified at once. MD 1 X Yes 2 ☐ No Montgomery Potomac Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20854 United States 12229 Seline Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edith Sterling Wayne Glickfield ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12229 Seline Way Potomac MD 20854 19a. Informant's Name/Relationship (Type. Print) William A. Srole - husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 X Removal from State National Crematory 7/18/2009 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service L 22 Name and Address of Facility Edward 1091 Rockville Pike Rockville MD 20852 M 01163 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HYPOXIC KESPIRATORY FAILURE 20AYS **Physician** ACUTE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 2DAYS IN EUMONIA Sequentially list conditions r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner 10 YEARS LUNG and Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by LOWER COBECTOMY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Certification: To

atter for u signed by the a peen

inding physician a use as the burialpage 2 s certificate After this funeral of

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

Physician: The law requires that the death certificate be executed To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funera

Medical

State

Registrar

		24a. Was an autopsy performed? 1 □ Yes 2 ☒ No 1 □ Yes 2 ☒ No
5. Was case referred to medical	26. Place	of Death (Check only one)
examiner? 1 ☐ Yes 2 🔯 No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nur	rsing Home 5 Residence 6 Other (Specify)
7. Manner of Death 1/SNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)  28b. Time of Unjury at Work?  M 1 ☐ Yes 2 ☐ N	28d. Describe how injury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

JULY 16 2009 D BOUL

30. Name and addition Therson who completed cause of death (Item 23a) (Type, Print)
WIRENDIA KURIALS AKENA WD - 121015TAR DREFT DL, GERDIANTOUP MO 2037B

31. Date filed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene ? () Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death  $J_u^{\text{Month}}$ <sup>D</sup>2<sup>y</sup>009 Norman Savner **Physician** 18, 4:11 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8100 Connecticut Avenue, #1222 Montgomery Chevy Chase 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day Year) 12/28/1918 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 M 2 F **Funeral** Hours Days Months IL 326-01-1722 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Marylan 10a, State 10b. County 28a-f show event, the Medical Examiner must be notified at 1≹Yes 2□No Director MD Chevy Chase Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20815 8100 Connecticut Avenue, #1222 United States "natural", or items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. Was Deceuent 2...
Armed Forces?
1 ⊠Yes 2 □ No
WWII Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 □Yes 2 🗵 No If Yes, Give Year or Dates: Specify: þ 3₺ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, It of Many injury or other traumatic event, College (1-4or 5+) Elementary/Secondary (0-12) Accountant Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Herman Savner Bessie Kalis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1439 Corcoran Street, NW Washington, DC 20009 Steven Savner-Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematroy 07/21/2009 Falls Church, VA 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc.  $1091\ Rockville\ Pike$ 21. Signature of Full Service Leus M01163 Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ulmonary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 5 Other (specify) signed by the a Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ cate has been signated by page 2 should b 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an regura autopsy performed? 1 Yes 2 No certificate I or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I 29a. Certifier 1 🖪 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 25 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 13

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature.

			1 - State of Maryland / Dep Registrar Ce	ertificate of D		tal Hygier Reg. N	7.002	24746	
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Edith Greenfield Steel			Date of Death Month E	Day Year Zoo9	3. Time of Death	
	Examin		4a. Facility Name (If not institution, give street and number) Washington County Hospital	Location of Death	4	4c. County of Death Washington			
	Funeral Director		5. Social Security Number  123-12-6362  6. Sex 1 M A F 7. Age (In yrs. last birthday, 90 Yrs.	Months Days	Hours Min. 7	Date of Birth Month, Day, Yea - 15 - 191	9. Birthp Coun 19 Bro	nlace (State or Foreign nx, NY	
	Maryland a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Line 10c. MD Washington Hagerst			1	0d. Inside City Limits 1 □Yes 2 ☑ No		
	with the	I Director	10e. Street and Number 17461 Cindy Lane	10f. Zip Code 2174	10		Citizen of What Coun	itry?	
0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examination in any injury or other traumatic event, the Medical Examination in any once.	d by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Wildowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No If Yes, Give A Year or Dates:	. Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 ☐ No	spanic Origin? (Specify ) n, Mexican, Puerto Ricar Specify:	Yes or No- n, etc.)	14. Race - Americ Black, White, e Specify: Whi	etc. te	
Maryland 21215-0036	within 72 hiene. r than "nati	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupat re kind of work done du DO NOT use retired) Ecretary	uring most of working	1	Kind of Business/Ind	•	
and	l be filed ntal Hyg ed other event,	Be	17. Father's Name (First, Middle, Last) unknown		18. Mother's Name <i>(Firs</i>	st, Middle, Maid Day			
aryl	should and Me s mark umatic	오		ling Address (Street a	nd Number or Rural Ro		•	Code)	
Z o	and 2 lealth a				Lane Hage		n, MD 21		
Baltimore,	t. Pages 1 tment of t tant: If ite ijury or of		4 Donation 5 Other (Specify)	ematory or other place, ourg Crem	200	9   Sm	nithsbur	g, MD	
Bal	permit Depar Impor any In		Douglas Hother	2.0.BOX 3	s of Facility lwin Thomp 110 Clear	Spring	neral Ho	ome,Inc	
	The law requires that the death certificate be executed the law requires that the has been signed by the attending physician and large 2 should be detached for use as the burial-transit and large 2.	ledical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):	HPOYIC E HTEAK	Rop 6	16		Interval Between Onset and Death	
P.O. Box 6	the death certific y the attending p ched for use as	Physician/Me		☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of delive Month	ery Day Year	
rds, P.	quires that the de en signed by the a uld be detached f	ρ	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause giver	n in Part I.		co use contribute to the	ne cause of death?	
Division of Vital Records,	<b>nysician:</b> The law requir his certificate has been si I director, page 2 should I	Completed				24a. Was an autopsy performed? 1 □Yes 2 2	prior to co	psy findings available mpletion of cause of 2  No	
Z Z	/sician s certifi director	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No  Hospital: 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Othor	26. Place of Death (Char: 4 \square Nursing Home	· · · · · ·	6 DOthor (Special	F-1	
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Divisio	no the Hospital or Attending Physician: To the Funeral Birector: After this certification the Funeral Birector: After this certification by the funeral director, to the Funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, the funeral director is the funeral director.	Certification:	2		es 2 □ No 28f. L	ocation (Street City or Town, Sta	and Number or Rura ate)	al Route Number,	
	To the Hospite within 24 hours To the Funeral completely fille	edical C	29a. Certifler (Check only one)  1 CertifyIng Physicien: To the best of my knowledge, dea control on the basis of examination and/or in and manner stated.	ath occurred at the time investigation, in my op	e, date and place, and c inion, death occurred at	due to the cause t the time, date a	e(s) and manner as s and place, and due to	stated. the cause(s)	
	To the within 2 To the complete	Me	29b. Signature and title of certifier	29c. License			Date signed (Month,		
			MOHAMMED AZIZ	D 468			120/09	)	
51	1-2		30. Name and address of person who completed cause of death (Item 23a) (Type, MOHAMMED A212 251E ANTIETHN	1 ST. HAGE	ERSTOWN A	10 21	740		
	Sta Registr	_	MOHAMMED A212 251E ANTIETIAN  31. Date filed (Month, Day, Year)  JUL 23 2009  32. Registrar's Signature	back					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** JULY 18 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number, Examiner PRINCE GEORGES MARYLAND HOSPITAL DUTHERN CLINTON 8. Date of Birth (Month, Day, ) Dec. 30, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1926 Philippines 1 □ M 2 🛛 F 82 218-19-7692 Director Usual Residence of Decedent 10d. Inside City Limits 72 hours after death with the Maryland 10c, City, Town or Location 10b. County 10a State d other than "natural", or items 23a or 28a-f show event, the Medical Eventing must be notified at 1 ☐ Yes 2 No Funeral Director Maryland Prince George's Fort Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20744 7511 Webster Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Asian Specify. Completed by 3 Midowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) At Home Homemaker and Mental Hygie is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Santos Ysabel Morales 4 8 1 Francisco ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Fleurdeliza S. Canlas- Daughter 12919 Asbury Dr., Ft. Washington, MD 20744 Health a permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🖾 Removal from State July 29,2009 Marikina, Philippines Loyola Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signature of Functal Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745 LA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **YULMONARY** Physician DSTRUCTIVE HRONIC disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner FBRILLATION Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed THRUMBOLYTOPENIA and burial-trar Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760. KIDNEY Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Vear Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Š ABETES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen PERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 □ Yes 2 □ No To the Hospital or Attending Physiclan: The within 24 hours after death.

To the Funeral Director: After this certificate his completely filled in by the funeral director, page 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number of death (Item 23a) (Type, Print) ROAD CLINTON MD 20735. 1502 SURRATTS

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MG 812011 **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. | Hours | Min. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) 5 Social Security Number **Funeral** Days 1 M 2 X F 3/7/1958 Washington, DC 51 Director 577-80-8163 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland or 28a-f show notified at 10a. State 10b County Yes 2 No Director Maryland Prince George's Riverdale 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number 0 items 23a or ner must be r 4802 Longfellow Street 20737 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 XNo "natural", or iten 1 Never Married 2 Married 1 Yes 2 If Yes, Give 1 ☐ Yes 2 😾 No Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Private 11 Child Care Provider 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be r and Mental F Margaret Williams Elbert J. Scott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau
once. Margaret Scott / Mother 4802 Lonfellow Street Riverdale, Maryland 20737 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/20/2009 LAUREL, MARYLAND Marvland National 22. Name and Address of FacilityPope Funeral Homes, P.A. 21. Signature of Funeral Service Licensee Charles 5538 Marlboro Pike Forestville, Maryland 20747 amp ications that caused by ne cause on each line Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or shock, or heart failure. List only the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** IVH Yack arria MENNOYIVE GO disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to lor as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Year in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) signed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 □ Probably 4 □ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 2 🗌 No 1 X Yes 2 No 1 X Yes To the Funeral Director: After this certifica completely filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 🗌 Yes 2 🗌 No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (check only

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

Medical

one)

Brot Gabriel 31. Date filed (Month, Day, Year) 2009 JUL 21

29b. Signature and title of certifier

32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

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215- be filed ntal Hyg rked otl	Be C	17. Father's Name (First, Middle, Last)  James W. Techtmann		Mother's Name (Fir Michelle			
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fitem 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  20b. Place of Disposition crematory or other programments of the company of the programment of the company of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of the programment of t		ery, Da	ate	20c. Location - City	or Town, State
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Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	0 B	examiner?  1 Ves 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3	DOA Oth	ner: Nursing H	ome 5F	Residence 6 Ot	ner:
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Divisal or / all or / safter of in the	ijį	3 Suicide 6 X Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, fa	actory, office buildi	ling, etc. 28f	. Location (S or Town, St	ate) 1 Bell	Rural Route Number, City Tower Ct.
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	Me	and manner stated.  29b. Signature and title of certifier	29c. License nu	umber		29d. Date signed (/	Month, Day, Year)
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		30. Name and address of person who completed cause of death (Item 23a)	4.D	4 D-W	4D 0100		
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	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation	<u> </u>				1	10d. Inside City Limits
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Division	or Attendil after death. Director: A in by the fu	Certification:	3 Suicide 6 Could not be determined		njury - At home, etc. (Specify)	farm, str	eet, factory, offic	се		28f. Location (Stre City or Town,	eet and Numb State)	er or Rur	al Route Number,
_	To the Hospitel or Atten within 24 hours after deal To the Funerel Director: completely filled in by the	edicai C	29a. Certifier (Check only one) 2 Medical Exami	sician: To the bes	of examination	lge, death and/or in	n occurred at the vestigation, in m	time, date an y opinion, dea	nd place, a	and due to the car ed at the time, da	use(s) and ma te and place,	anner as s and due t	stated. to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of centifier				29c. Lice	ense number		29	d. Date signe	d (Month,	Day, Year)
	->-0		+ KVaV	eun	, wis		D	005.	299	19	7/20	19	
(	n		30. Name an address of person who co	ompleted cause of	death (Item 23a	a) (Type,	Print)	1 12.	. ^	6 6:	nrm is	m	Day, Year)
	00.5		ALI RAHIMIA  31. Date filed (Month, Day, Year)	32. Refais	strar's Signature	2	CLIG101	INIV	66	- 6 661	AIGIA	1.77	0.0103
	Sta Regist		31. Date filed (Month, Pay, Year) JUL 20 20	009 Sen	wa p	1. 19	arke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per Th 8894 8-13-09 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 5 30 P M **Physician** 24 2009 07 9 Regina Teller /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Good Samaritan Hospital Baltimore Birthplace (State or Foreign Country) 0102 5. Social Security Number 5837 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 M 2 F 213-28-<del>5557</del> July13,1931 Maryland Director 78 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State the Marylan 9 od other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1√∑Yes 2 □ No Director Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with U.S.A. 21206 6505 Hilltop Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∏Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐XNo Specify. Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fill and Mental H 7 Is marked traumatic e Hildagard Schaeflein Jerome Kraus ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6505Hilltop Avenue, Baltimore, Maryland21206 27 tem 27 other to Teresa J. Teller/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter
any injury or oth 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Bayview Crematory 7-27-09 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licenses michael P. margull 6009Harford Road, Baltimore, Maryland21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PANCREATITIS Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): physician ; Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) has been signed by the 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown CONGESTIVE HEART FAILURE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ATRIAL FIBRILLATION certificate ha performed? 1 ☐Yes 2 🗹 No 1 ☐Yes 2 ☐No ESOPHAGEAL DYSMOTILITY DISTRDER director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After th funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation ithin 24 hours after death.

the Funeral Director: A suppletely filled in by the fu 2 Accident 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES 000 FULY 24, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KUMAR BALTIMORE NIRMAL 5601 BLVD MD LOCH RAVEN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

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		State		artment of Healt rtificate of Dea			-211119	24752
		Registrar  1. Decedent's Name (First, Middle, Last)		Tillicate of Dea		Reg.	No.4 0 0 J	3. Time of Death
Physicia	ın	Agnes Mary Varady				Month	Day Year 2009	11:28 AM
/Medic		4a. Facility Name (If not institution, give street and number)	,	4b. City, Town, or Locati		July 17	4c. County of Deat	
Examin	er	3790 Old Denton Road		Federals			Carol	line
Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	If Under 1 Year If Un Months Days Hou	nder 24 Hrs. g	3. Date of Birth (Month, Day, Ye	9. Birt	hplace (State or Foreign
Director			67 Yrs.	Working Days Floor		Aug. 19,	1941 Ne	w York
and	1	Usual Residence of Decedent  10a. State 10b. County 10c	c. City, Town or Lo	ocation				10d. Inside City Limits
Aaryk f sho	ō	MD Caroline	,	Federa1	shuro			1 □ Yes 2 No
the 1	rec	10e. Street and Number		10f. Zip Code	. D D d I g	10g.	Citizen of What Co	untry?
3a or	Funeral Director	3790 Old Denton Road		21	632	U:	nited St	tates
death	ner	11. Marital Status 12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of Hispanic If Yes, specify Cuban, Mex	c Origin? (Spec	ify Yes or No-	14. Race - Ame Black, White	
rs after r, or ite	by Fu	1 □ Never Married 2 ★ Married 1 □ Yes 2 ★ No If Yes, Give Year or Dates:		1 □Yes 2 □xNo Spe		ioan, cio.,		White
72 hou natura		15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation kind of work done during i DO NOT use retired)	most of working	166	. Kind of Business/	Industry
within iene. than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 1 2		memaker	· ·		Own Hon	ne
filed I Hyg other	Be C	17. Father's Name (First, Middle, Last)		18. M	flother's Name (	First, Middle, Maid	den Surname)	
Ald be Alenta rked tic ev	일	Herman Henry Speed		A	gnes I	Oownie :	Summers	
and has ma		19a. Informant's Name/Relationship (Type. Print) Spou	se i	ng Address (Street and Nu			-	
and 2 ealth m 27 i		Phillip R. Varady, Sr./	3/90	0 01d Denton				
Pages 1 ent of H nt: If iter ry or oth		11 Burial 2 ALTernation 31 Bernoval from State		osition (Name of matory or other place) e Crem. Ctr.	07/20		ambridge	
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Madical Experiment in ust be notified at once.		21. Signature of Funeral Service Licensee		2. Name and Address of Fa 216 N. Main				
		23a. Part I. Enter the disease, or complications that caused the						Approximate Interval Between
Physician	L	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	-dia	Amel				Onset and Death
/Medical		resulting in death)  Due to (or as a co		• 11. 7.	~~			
Examiner		Sequentially list conditions, b.	orana	Arry Arra	<u>، ر</u>	Sca Je		year
led isit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	nsequence of):		•			•
cate be executed physician and the burial-transit	xan	resulting in death) Last  C  Due to (or as a co	nsequence of):					
sician	dical E							
tificate g phy as the	Φ 1	u.						
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnant at time 1 □ Live birth 2 □ 4 □ Pregnant at time 1 □ Unknown	Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of de Month	livery Day Year
signed by	占	Part II. Other significant conditions contributing to death but no	ot resulting in the u	Inderlying cause given in P	Part I.	23e. Did tobac	co use contribute to	the cause of death?
quires n sigr ald be	d b	Arral F. ballaring HTIN	Hearly	n. dem		1 □ Yes	2 □ No 3 🗗 P	robably 4 Unknown
e law requir has been s e 2 should	Completed		7//			24a. Was an autopsy	prior to	utopsy findings available completion of cause of
	Con					performed 1 □ Yes 2 □		2 □ No
Physician; The Is this certificate har all director, page 2	Be	25. Was case referred to medical examiner?  Hospital: Hospital:		Othor		(Check only one)		
Phys this	۲.	1 ☐ Yes 2 ☐ No ☐ 1 ☐ Inpatient  27. Manner of Death 28a. Date of Injury	2 ER/Outpatie				e 6 Other (Spe	cify)
Attending Physician; or death. ector: After this certification by the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director director, the funeral director director, the funeral director director, the funeral director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director direc	tion	Natural 5 ☐ Pending (Month, Day, Ye	ar) Injury	of 28c. Injury at Work?  M 1 □ Yes		3d. Describe how i	njury occurred	
Atten r deat ector: by the	fica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury -	At home, farm, str					ural Route Number,
al or safter	Certification: To	4 ☐ Homicide determined building, etc. (S	Specify)			City or Town, S	itate)	
To the Hospital or Attendin within 24 hours after death.  To the Funeral Director: Aft completely filled in by the fun	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of m 2 Medical Examiner: On the basis of examiner and manner stated.						
To th withir To th comp	Me	29b. Signature and title of certifier		29c. License numl	ber	29d.	Date signed (Mont	th, Day, Year)
)		30. Name and address of person who completed cause of death  31. Date filed (Month, Day, Year)  32. Registrar's services and title of certifier  33. Registrar's services and title of certifier  34. April 19. 35. Registrar's services and title of certifier  35. Registrar's services and title of certifier  36. Name and address of person who completed cause of death  37. 38. Registrar's services and title of certifier  38. Registrar's services and title of certifier  39. Name and address of person who completed cause of death  31. Date filed (Month, Day, Year)  32. Registrar's services and title of certifier  33. Registrar's services and title of certifier  34. April 19.	(11	Hoors	122	•	July 20	7 2009
		30. Name and address of person who completed cause of death	(item 23a) (Type, Y	Print)	C. d.	(dur	40 77	6.72
Sta		31. Date filed (Month, Day, Year) 32. Redistrar's	Signature	hadel	( ( 20)	7	MY A	- 0
Registra	ar	JUL 21 EUS	v p. g	700				

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INK OINK	1- For State Control of Peatth and Wentan ing	Reg. No.		
Physician/	Registrar  1. Decedent's Name (First, Middle,Last)	Date of Death     Month Day	Year	3. Time of Death
ledical Examine	101001 111001110 10111101 1011010	July 11, 2009	c. County of Death	1112 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 2217 University Blvd. # 203  Hyattsville		Prince George	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	_ `	(/DD/YYYY) 9. Bir Foreig	
Director	none   TX M 2 F   50 Yrs.   Months   Days   Hours   Min.	8/22/19	958	untry) Honduras
iny	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Aaryland 28a-f show any 1 at once.	Maryland Montgomery Rockville			1 X Yes 2 No
the Maryland a or 28a-f sh iified at once	10e. Street and Number 10f. Zip Code	10g. Cit	tizen of What Cou	ntry?
th the Maryland 23a or 28a-f sho notified at once.			Honduras	isen Indian Blook
death with r items 23 nust be no	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. 14. Was Decedent of Hispanic Origin?) (Sp. 15. Was Decedent of Hispanic Origin?) (Sp. 15. Was Decedent of Hispanic Origin?) (Sp. 16.	Rican, etc.)	White, etc.	ican Indian, Black,
s after de ral", or imer mu by Fu	2 Wildowed 4 Divorced If Yes Give Year 1X Yes 2 No specifyHoned	luran	Specify: Wh	nite
hours a natura (xami)			. Kind of Business/	Industry
5-0036 ed within 72 hour lygiene. other than "natu	Elementary/Secondary (0-12)   College (1-4 or 5+)   Landscaping		Greenstor	ne Co.
5-00 led with Hygiens other	17. Father's Name (First, Middle, Last)  18. Mother's Name	(First, Middle, Maide		
21215-0036 hould be filed within 7 hould be filed within 7 hd Mental Hygiene. is marked other than tite event, the Medical To Be Comple		Los Angel		
O d b is it	19a. Informant's Name/Relationship (Type, Print) (Brother) 19b. Mailing Address (Street and Number of 13203 Grenoble In.	Rockville	, MD 2085	53
ore, MC ss i and 2 st of Health at If item 27 her traums	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date 20c	Location - City or	
MOFE Pages 1 nent of H nut: If i	Tar bullar 2   Cremation 3   Removal non-state	y 29,20 <b>0</b> 9		
Baltimore, permit. Pages I as Department of He Important: If ite	21. Signatu of Funeral Service Licen 22. Name and Address of Facility	ndon/Hale	Funeral	Home
Physician	23a. Pirt I. Enter the dislase, or implications that caused the death. Do not enter the mode of dying, such as cardiac or	or respiratory arrest, si	hock, or heart	Approximate interval Between Onset and
'Medical - caminer	failure. List only one se on each line.  Immediate Cause (Final disease a. Multiple Sharp Force Injuries			Death
tailinei	or condition resulting in death)  Due to (or as a consequence of):			
Į.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
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that the death certificate be executed ned by the attending physician and detached for use as the burial - transit by Dhysician / Madical Ex	UNPENDED AMENDED			
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Box 687  e death certific the attending p ed for use as th	past 12 months?  4 Pregnant at time of death 5 Other (Specify)			
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Vital Rec ysician: The l his certificate l director, page	25. Was case referred to medical 26.Place of Death (Check	p		
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Division o spital or Attending tours after death. neral Director: After filled in by the fune	4 Momicide determined (Specify) Multi-Family Apt.	2217 University B	lvd. # 203, Hyati	
Division of North Hospital or Attending Physicial 2 hours abled death and To the Funeral Director. After the Completely filled in by the funeral Madding Confiferation. Treasure of Confiferation.		d due to the cause(s) at the time, date and	and manner as sta place, and due to	ated. the cause(s)
To To Com	and manner stated.  29b. Signature and title of certifier  29c. License number		d. Date signed (M	
	O.C.M.E.	Ju	uly 12, 2009	
2	30. Name and address of person who completed cause of death (Item 23a)	4D 24204		
R2	Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, N	/IU 21201		
Stat	e 31. Date filed (Month, Day, Year)  32. Registrar's Signature  33. Registrar's Signature			

Kenneth Winters 09-05436 Plea

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 24754

UNK UNK	1	State of Maryland	Department Certificate			and	Menta	ıl Hyg		No.		2 410	
Physiciar		e <b>gistrar</b> . Decedent's Name (First, Middle,Last)		-				2.	Reg.			3. Time of Death	
Medical Examin		KENNETH RICHARD WIN	ITERS						Month [ July 11, 200	9		1530 hrs	
		<ul> <li>Facility Name (if not institution, give street and number)</li> <li>205 Kent Avenue</li> </ul>		41	La Plata		ocation of I			4c. County o Charles			
Funeral			e (In yrs. last birthday)	)	If Under 1	Year Days	If Under:	24Hrs. Min.	8. Date of Birth AUGUS'I	(MM/DD/YYYY) 26,	Foreig	hplace (State or WASH, D.C.	
Director	L	219-72-3280   1XXM 2 F	50	Yrs.	Months	Days			1958		Cou	untry)	
G å		Jsual Residence of Decedent  0a. State 10b. County	10c. City, Town or Lo	catio	on							10d. Inside City Limits	
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ath wit	uneral	1. Marital Status 1. XXNever Married 2 Married Armed Forces	,	Was If Ye	Decedent s, specify (	of Hispa Cuban, I	anic Origir Mexican, F	Puerto R	cify Yes or No- ican, etc.)	White	, etc.		
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36 in 72 h han "n lical E	Supply Clerk   13. Decedents Education (Specify this Highest grade completed)   15. Decedents Education (Specify this Highest grade completed)   16. Decedents Education (Specify this Highest grade completed)   17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Last)   1										AΙ	R STATION	
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imore, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  Tritem 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State   147 MAUREEN PLACE, DOVER, DE 19										901	
e, N. I and I Health Fitem	ı	20a. Method of Disposition	20b. Place of Dis	sposi	tion (Name	of cem	etery,	JUL	Y 27,	20c. Location			
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Physician		23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.	the death. Do not ent	ter th	e mode of	dying, s	such as ca	rdiac or	respiratory arre	st, shock, or he	art	Approximate Interval Between Onset and	
'Medical aminer		Immediate Cause (Final disease or condition resulting in death)  a Probab1  Due to (or as a cons	e cardiac	aı	rrhytl	hmia	1					Death	
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- 4	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a cons	equence of):										
iO,  e be executed ysician and burial - transit	삚	d		_				_				+	
30, te be ex ysiciar	ledical	X UNPENDED 23a.I	PII.27.permome of pregnancy	m <u>E</u>	<b>.</b> G90	2 4	/30/ <u>1</u>	0 TI		23d. Date o	f delive	y	
Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	sician/M	3b. Was decedent pregnant in the	2	Fe	tal death	3	Ectopic	pregnar	псу	Month		Day Year	
OX (eath ce attence attence for use	sici	1 Yes 2 No 9 Unknown g Unknown	it time of death 5	Otl	her (Specil	fy)							
D. B nat the d ed by the	Phy	Part II. Other significant conditions contributing to dea	th but not resulting in	the u	ınderlying c	ause gi	iven in Par	t I.				the cause of death?	
ries that	d by	Chronic alcoholism										bably 4 Unknown	
cords, law requir	Completed								24a. Was a autop:	sy		utopsy findings available completion of cause of	
Rec The la	E O								1 🗸 Yes		<b>V</b>	es 2 No	
tal Rec cian: The certificate	Be	25. Was case referred to medical examiner?   Hospital:		4:4		- 4	of Death ( Other		page 1	Residence 6	<b>√</b> Oth	er: Scene	
1 of Vi ling Physi After this	O 1 Yes 2 No Impatent 2 Erroutpatient 3 DOA 4 Not sing Note 5 Nesscribe how injury occurred												
on c ending ath. rr: Af	tion	Natural 5 Pending	Year)			1 Y	'es 2	No					
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of	Injury - At home, farm,	stre	et, factory,	office b	uilding, etc	5.	28f. Location (S		er or F	tural Route Number, City	
Di spital pours a neral I	Cert	4 Homicide determined (Specify)		_									
Div To the Hospital o within 24 hours af To the Funeral D	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of examiner: On the basis of examiner: On the basis of examiner.	my knowledge, death o amination and/or inves	occur stiga	rred at the t tion, in my	time, da opinion	ite and pla , death oc	ice, and curred a	due to the caus t the time, date	e(s) and manne and place, and	er as sta due to	ited. the cause(s)	
To t with	Med	29b. Signature and title of certifier	1.				e number					onth, Day, Year)	
	.00	Mouse mether				O.C.	M.E.			July 12, 2	009		
0		30. Name and address of person who completed cause of				ot D	altima = =	MD	21201				
DB		Margarita Korell MD. Assistant Medica	cala Ciamatura		enn Stre		aitiinore	:, IVIU 4	<u> </u>				
St	ate	31. Date filed (Month, Day Year) 32. Regist	wa B.	1	alle								

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records.

State Registrar

30. Name and address of p

31. Date filed (Month, Day,

Ilcda

CALIOII

mero

Year)

erson who completed cause of death (Item 23a) (Type, Print)

32. Redistrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar		State of Ma	ıryıana /		irtment of H tificate of I		na Men		eg. No.	JUS	24/56
			Decedent's Name	(First, Middle, Las	st)						Date of Deat Month	h Day 1	Year	3. Time of Death
	Physicia /Medic		Arthur	Dawson W	a11					J	117	12	200	
	Examin	er			street and number)			4b. City, Town, o. Cheverly		Death			unty of Death	eorge's
	F		5. Social Security No		ospital Ce	nter e (In yrs. last b	irthday)	If Under 1 Year	If Under 24	1 Hrs. 8. E	Date of Birth Month, Day,			place (State or Foreign
ø	Funeral Director		247-24-96	1	<b>X</b> M 2□F	90	Yrs.	Months Days	Hours	Min. 08	Month, Day, 8/08/1	1918	Col	NC NC
	pu 🛊		Usual Residence of 10a. State	Decedent 10b. County		10c. City, To	wn or Lo	cation					T	10d. Inside City Limits
	Aaryla f sho	o	MD	Prince G	eorge's	Upper								1X Yes 2 No
	28a-	rect	10e. Street and Nun					10f. Zip Code			1	0g. Citizen	of What Cou	intry?
	th with 23e o	ai D	2910 Hatl	boro Plac	e			2077					USA	
	should be filed within 72 hours after death with the Maryland of Mental Hygiene marked other than "natural", or tiems 23a or 28a-f show marked other than "natural", or tiems 23a or 28a-f show mail: event, the Madical Examination to notified at	Funeral Director	11. Marital Status		12. Was Decedent I Armed Forces? 1 ☐ Yes 2 🛣	Ever in U.S.	13. \	Vas Decedent of H Yes, specify Cuba	lispanic Origi an, Mexican, I	n? (Specify Puerto Rica	Yes or No- in, etc.)		Race - Amer Black, White	
36	rs afte	by F	1 Never Marri	ed 2 X Married 4 □ Divorced	Il Yes, Give Year or Dates:	10		I∏Yes 2█ No	Specify:			Sp	ecify: B1	ack
Š	2 hou		//	15. Decedent's Ed		16	a. Deced	lent's Usual Occup	ation	of working		16b. Kind	of Business/l	ndustry
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2	filed with Hygiene. other ther		17. Father's Name (	/First Middle Last		ļ	Cust	odian	18. Mother's	s Name (Fir	rst, Middle, i		ic Sch	001
-	0 = 0 5	o Be	James Wal						Leavi				,	
Maryland 21215-0036	should be and Mental marked o	P	19a. Informant's Na		Type, Print)	19	9b. Mailir	ig Address (Street	and Number	or Rural Ro	oute Number	, City or To	own, State, Z	ip Code)
Ĕ	and 2 alth a 27 to		James Wal	11s/Son				Hatboro						
ore	of He of He If item or oth		20a. Method of Disp		Removal from State	20b. Place ceme	of Dispo tery, crer	sition (Name of natory or other plac	ce)	Date		20c. Locat	ion - City or 1	own, State
Baltimore,	t. Pag tment tant: ijury o			5 Other (Specif	y)	Roan	oke	Salem Bar . Name and Addre	tist0	7/25/2	2009	Garys	bury,	NC
Ba	permit. Pages 1 and 2 should by Department of Heatils and Menta Important: If item 27 is marked any injury or other traumatic e <u>once</u> .		21. Signalura of Fu	- LOBI	to Con	$\langle \cdot \rangle$		500 Aller						
(6)	6 4 y		23a. Part I. Enter th	he disease, or com	plications that caused one cause on each lir	the death. D								Approximate Interval Between
	Physician		Immediate Cause (	(Final	one cause on each in	FAT	AL	CARd	iac	Arrh	hytmi	۵	[	Onset and Death
b	/Medical Examiner		resulting in death)	(	Due to (or as	a consequenc	e of):			D 4	<i></i>			
		7	Sequentially list con	nottions.	b. Due to (or as	a consequenc	e of):	Corona	wy	Jynd	romu			
	uted d ansit	Examiner	if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	orlying injury		A	ner	Card Corona	chro	nii	6000	( ( s)		
o,	en and rrial-tra	Еха	resulting in death) I	Last	Due to (or as	a consequenc	e of):							
58760,	icate be executed physicien and s the burial-transit	dicai			d									
_		0	IF FEMALE:		23c. If yes, outcome	of pregnancy						230	I. Date of deli	verv
Box	death a atten d for u	Physician/M	in the past 12	months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal dea		Ectopic pregnanc Other (specify)	y				Month	Day Year
P.O.	at the by the tacher	hys	9 □ Unknown		9⊡ Unknown					-				
	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	by	Part II. Other signif	ficant conditions	contributing to death b	ut not resulting	g in the u	nderlying cause giv	ren in Part I.		23e. Did to	\	_	the cause of death?
Records,	w requir been si should	Completed	/	D.	Vicers					-				topsy findings available
Rec	helaw shasl ge 2 s	mpi		1 VESIUVE	0 · N						24a. Was a autop perfor	med?	prior to death?	completion of cause of
	an: T tificate tor, pa	Be Co	25. Was case refer	red to medical	Situ 1)	erang	ema	ent	26. Place	of Death (C	1 ☐ Yes heck only o	2 <b>X</b> No	T T T T T T T T T T T T T T T T T T T	No
<u></u>	Physician: r this certificanal director,	To B	examiner?	No	Hospital: 1 X Inpatie	ent 2 ERV	Outpatier	nt 3 DOA	ner: 4 🗆 Nur:	sing Home	5 🗌 Resid	ence 6	Other (Spec	afy)
0 0	ing Pl		27. Manner of Deat	5 Pending	28a. Date of Inju (Month, Da	ry y Year) 28t	. Time o Injury	Wo			. Describe h	ow injury o	occurred	
Division of Vital	death ctor: /	licat	2 ☐ Accident 3 ☐ Suicide	investigatio	e 290 Place of Ini	urv - At home.	Jarm. sti	M 1 =	Yes 2□N		Location (S	Street and N	Number or Ru	ıral Route Number,
<u>S</u> .	al or A s after if Direct id in by	Certification:	4 🗌 Homicide	determined	building, et	c. (Specity)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or Ton	m, State)		
	tospit thours unere	edical (	29a. Certifier (Check only	Certifying Pl	nysician: To the best miner: On the basis o	of my knowled	ige, deat	h occurred at the tr	me, date and	place, and	due to the dat the time, d	cause(s) and pl	nd manner as ace, and due	stated. to the cause(s)
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medi	one) 29b. Signature and		and manner sta	ated.		29c. Licens						h, Day, Year)
N.	T w D	-	200. Digitature and	Whil	al Ti-	. > . 5	>	700	5281	65		Jul	J 16t	1 2009
	7		30. Name and addr	ress of person who	completed cause of c	leath (Item 23:	a) (Type.	Print)		- ~		V - 1	+	1
	3		Michael I		3001	Hospita	al D	rive, Che	everly,	, MD 2	20785			
	Sta Regist		31. Date liled (Mon	2009	32-Region	HOSOLU ars Signature	2							

			For State of Mary Maria /		tificate of D		-	Reg. No.	2009	2475
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of De Month	Day	Year	3. Time of Death 12:55 A.M
	/Medic	al	Eleanora Merle Anderson  4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I	agation of Dogth	August	3,	2009 County of Death	<u> </u>
,	Examin	er	Stella Maris		Timon			40.	Baltimo	
	Funeral Director		5. Social Security Number 025-09-8362		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 8/30/			place (State or Foreign ntry)
	/land		Usual Residence of Decedent           10a. State         10b. County         10c. City, To	Town or Loc	cation		_			0d. Inside City Limits
	e Mary	ctor	Maryland Baltimore		Phoenix	Σ.				1 ☐ Yes 2 ☐ No
	ath with th 23a or 24 ust be no	Funeral Director	10e. Street and Number 13402 Blythenia Road		10f. Zip Code 2113			Unit	zen of What Cou ced State America	eś
9000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm M. dical Eventing I nest bun filled at once.	d by Fune	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Was Decedent Ever in U.S. Armed Forces?  1 □ Yes, Give Year or Dates:		Vas Decedent of His Yes, specify Cuban □Yes 2∑No	spanic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		14. Race - Ameri Black, White, Specify: W11	etc.
Baltimore, Maryland 21215-0036	within 72 h lene. <b>than "natu</b> hy Malical	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+) 1.2	(Give I life. D	lent's Usual Occupa kind of work done du DO NOT use retired) IOMEMAKET		ing		nd of Business/In	dustry
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e, l	1 and Health em 27 ther t		Mrs. Carol A. Panciera/dau.		2 Blyther		Phoeni Date		faryland cation - City or To	
timor	t. Pages rtment of rtant: If it		4 □ Donation 5 □ Other (Specify) Cha	ıs Fun Del-	sition (Name of latory or other place Neral BelAir	200	t 3,	Fore	est Hill	, Waryland
Ba	permi Depa Impo any In		21. Signature of Fundal Service Licensee		2325 Yo	ork Road	Timoni	Lum,	Cremati Marylan	
-	Physician		Part 1. Enter the disease, or complication that caused the death. I shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	Do not ente	er the mode of dying	, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a. Due to (or as a consequence)	ice of):	الالاناكا	2008				
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68760,	rificate be executed ng physician and as the burial-transit	al Examiner	Sque tildily the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condit							
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P.O. Box	that the death cer ned by the attendin detached for use	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	eath 3□	Ectopic pregnancy Other (specify)				23d. Date of deliv Month	rery Day Year
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Vita	sician: The certificate h rector, page	Be (	25. Was case referred to medical examiner?			26. Place of Deat		ne)		
oto	Phys r this ral dir	5	1  Yes 2  No Hospital: 1  Inpatient 2  □ EP.  27. Manner of Death 28a. Date of Injury 28	NOutpatient  Bb. Time of	t 3 ☐ DOA Other	A Nursing Ho	me 5 Resi		6 ☐ Other (Special of the Control o	(fy)
on	nding F ath. r: After e funera	ation	1 ☐ Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation	Injury	Work?	es 2 □No	zoa. Decombe	now mjar	y boouried	
Division of Vital	tal or Attences after death	Certification: To	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	eet, factory, office		28f. Location (: City or Tox	Street an vn, State	d Number or Rur )	al Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dires completely filled in b	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination on the basis of examination one)	dge, death and/or inv	occurred at the tim estigation, in my op	e, date and place inion, death occur	and due to the red at the time,	cause(s)	) and manner as d place, and due	stated. to the cause(s)
	With Com	Σ	29b. Signature and title of certifier	0	29c. License			29d. Dai	te signed (Month,	
			Jennifel mey la	20) (7::::	1 7	57629		(	36/03/	2009
	WV		30. Name and address of person who completed cause of death (Item 23 JENNIFER HAUF, CRNP 2300 L	OULANI	EY VALLEY	ROAD T	IMONIUM	MD	21093	
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	To No.	/					

2009

AUGUST 2,

ANDERSON, E MERLE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 24758 09-05540 State of Maryland / Department of Health and Mental Hygiene Raymond Wallace Asbury 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ July 15, 2009 1408 hrs **Medical Examiner** Raymond Wallace Asbury c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Washington Hagerstown 11 West Baltimore Street If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Numbeunk 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Foreignunk Months Days Hours Director Jan 19, 1955 1 X M 2 Yrs Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City, Town or Location BIR Yes 2 X No 28a-f show Hagerstown MD Washington or items 23a or 28a-f sho must be notified at once. be filed within 72 hours after death with the Maryland Directo 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number 11 W. Baltimore Street 21740 USA Funeral Was Decedent Ever in U.S. Armed Forces? unk 11. Marital Status unk 12. Was Decedent Ever 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black. White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married Married Yes If Yes, Give Year Specify: white Yes 2 X No specify: If item 27 is marked other than "natural", her traumatic event, the Medical Examiner Widowed 4 Divorced þ 16b. Kind of Business/Industryunk 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work don Completed during most of working life. DO NOT use retired)  $\, unk \,$ Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 unk unk permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. 17. Father's Name (First, Middle, Last) unk 18.Mother's Name (First, Middle, Maiden Surname) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 111 Penn Street; Baltimore, Maryland 21201 O.C.M.E.20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 X Other Specify: in state Signature of Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board 655 Wastername Marvland 21201 Ronald S. Wade W. Baltimore Street Baltimore, Maryland 21201

Cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Part I. Enter the disease, of compl **Physician** allure. List only one cause on each line Between Onset and /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Exam (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit ica 23a,27,perME, g894 8/5/09 TT the attending physician and for use as the burial -X UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Month Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) icate has been signed by the att page 2 should be detached for Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ē Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 1 🗸 Yes No No 25. Was case referred to medical 26.Place of Death (Check only one) funeral director, Be Hospital: 1 Other<sub>4</sub> Nursing Home 5 Residence 6 V Other: Scene Inpatient ER/Outpatient 3 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Dey,Yeer 27. Manner of Death 28b. Time of Injury Certification: 1 X Natural Yes 2 Pending To the Funeral Director: filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 16, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year

**ORIGINAL** 

32. Registrar's Signature

OCME

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** UIS 2009 August 3:41 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford 1311 Allenby Court Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** ty⊒M 2□ F Months Days Hours Min Director 580-76-5627 12, 1938 Puerto Rico Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Department of Health and Mental Hyglene. Important: yor items 23a or 28a-f shov any Injury or other traumatic event, the Wolfan Evant increase by rettlined at 1 ☐ Yes 2 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1311 Allenby Ct. 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Never Married 2 ☑ Married Specify: Puerto Rican 1 Yes 2 No ģ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Government Lt. Colonel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Luis Herminio Alvarez Maria Luisa Garcia 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Christine O. Garcia</u> / Wife 1311 Allenby Ct., Bel Air, Maryland 21014 20c. Location - City or Town, State 20a, Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp! 8-4-09 Towson, Maryland 21. Signature Juneral Service Licenses any Ir McComas Fune all Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any least ground list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 → Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

To the Hospital or Attending Physician: The law requires that the death certificate be executed -tran and burial physician a Box 68760, ending p atter for u signed by the a d be detached for Ö ۵. s certificate has be irector, page 2 s

28a-f show

and 2 should be filed within 72 hours after

Pages 1

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Division of Vital Records,

State Registrar

Medical

and manner stated.

Tight Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

PH-TSICIAN

20058475

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PUNTON 602. ATMOUD RUAD

NJUA Registrar's Signature 31. Date filed (Month, Day, Year)

determined

4 Homicide

(Check only one)

PHZLIP

29b. Signature and title of certifier

29a, Certifier

AUG 0 4 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Russell Talbert Bell 9:35 P.M 31, 2009 July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** NOM 2□ F Months Days Hours 50 Yrs. 212-73-7864 Director 2/4/1959 Freeland, Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Freeland Director 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21053 2728 Chickentown Road OF America Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Never Married 2 Married White 1 ☐ Yes 2 ☑ No Specify. \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event Thesis School Bus Driver Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Melvin Talbert Bell Violet Stiffler ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Susie Markline/ sister New Freedom, Pennsylvania 17349 149 Bond Street 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Augušt 5, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 White Hall, Maryland Weth. Church Cemetery 22. Name and Address of acility.
eaceful Alternatives Funeral & Cremation Ctr., P.A. 21. Signature of Funeral Service L 2325 York Road Timonium, Maryland 21093 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Non Hodg **Physician** unknown disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 - Nursing Home 5 - Residence 6 Other (Specify) Hospice 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending

68760 Box O σ, Rècords, Vital ð Division

sician and burial-trans

attending physician for use as the buria

signed by the a d be detached fi

page 2 should

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After

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show

ed other than "natural", or items 23a or 28a-f show event, the Medical Eventine in ust be notified at

, o.

Maryland 21215-0036

Baltimore,

that the death certificate be executed Physician: The law requires Hospital or Attending after death.

State

29a. Certifier (Check only

3 Suicide

4 ☐ Homicide

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Marme and address of person who completed cause of death (Item 23a) (Type, Print)

investigation 6 ☐ Could not be determined

32 Registrar's ignatu

DHMH 17 Rev 1/2001

Registrar

DHMH 17 Rev 1/2001

State Registrar Reisterstown

25 Main Street #200

32. Registrar's Signature

Den

31. Date filed (Month, Day, Year)

21136

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	tate of Maryla		rtment of Hartificate of L			ene 1. No. 2   1   1   9	24762
Physic		1. Decedent's Name (First, Middle, Last) Thomas Arth	ur Bower		_		2. Date of Death Month July 3	Day Year 1, 2009	3. Time of Death
/Medi Exami		4a. Facility Name (If not institution, give stree Manor Care Dulaney	et and number)		4b. City, Town, or		-	4c. County of Death	1
Funeral Director		5. Social Security Number 6. Sex 217-60-4067	7. Age (In yi	s. last birthday) 51 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, )		nplace (State or Foreign intry) Maryland
Maryland t-f show fied at	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimor		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 227No
th with the 23a or 28a ist be noti	al Director	10e. Street and Number 1303 McPherson C	ourt		10f. Zip Code 21.09	3		citizen of What Cou United Sta of America	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any once.	by Funeral	1√2 Never Married 2 Married	Was Decedent Ever in Armed Forces? 1 ☐ Yes 2☐ No If Yes, Give Year or Dates:		Was Decedent of Hi fYes, specify Cuba I∐Yes ŽEŽNo	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify:	
21215-0036 sd within 72 hours af gigene. er than "natural", or the Medical Exam	Completed	15. Decedent's Educati (Specify only highest grade co		(Give life. L	lent's Usual Occupa kind of work done o DO NOT use retired alesman	ation furing most of wor )	king	Specialty	
Maryland 2 td 2 should be filed tht and Mental Hygi z7 is marked other traumatic event, ti	To Be Co	17. Father's Name (First, Middle, Last) Francis Eugene Bow	er				ne (First, Middle, Ma Agnes Gli	aiden Surname)	
and 2 short and 2 short and 27 is mare trauma	1	19a. Informant's Name/Relationship (Type. Mrs. Helen A. Bower/	mother	1303	3 McPhers		Lutherv		land 21093
altimore, rmit. Pages 1 ar partment of Her portant: If item y Injury or othe		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	Evans Fu Chapel-	natory or other plac uneral Bel Air	Aug 20	ust 1, $_{ m F}$		, Maryland
Depariment of the post of the	3	21. Signature of Fuheral Service Licensee	4		2325 York	Road T	ımonıum,	Maryland 2	
Physician /Medical		23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death)	ause on each line.	clerop			correspiratory arres		Approximate Interval Between Onset and Death
Examiner pung	Examiner	Sequentially list conditions, if any teaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Renal Dus to (ur as a cons	for la	me				5 /00
68760, ificate be executed g physician and as the burial-transit	dical	d	Due to (or as a cons	equence or):					
Records, P.O. Box 6 The law requires that the death certific te has been signed by the attending tage 2 should be detached for use as	Physician/Me	IF FEMALE: 23c. 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome pf pred 1□Live birth 2□F 4□Pregnant at time o 9□Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
cords, P w requires that been signed b should be deta	by	Part II. Other significant conditions contrib	uting to death but not r	esulting in the ur	nderlying cause give	en in Part I.		cco use contribute to	the cause of death?
	Completed						24a. Was an autopsy perform 1 Yes 24	prior to c ed? death?	topsy findings available completion of cause of 2 No
or Vital F Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death	oital: 1 ☐ Inpatient 2 28a. Date of Injury	ER/Outpatien		er: 4 Nursing H	ath <i>(Check only one)</i> lome 5 Residen  28d. Describe how	ce 6 □Other (Spec	city)
Division or Vital Records,  To the Hospital or Attending Physician: The law requires t within 24 hours after death.  To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be o	Certification:	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year, 28e. Place of injury - Al building, etc. (Spe	Injury home, farm, str	M 1□	Yes 2 □ No		eet and Number or Ru	eral Route Number,
ne Hospital n 24 hours a ne Funeral I	Medical C	29a. Certifier 1 Certifying Physici (Check only one) 2 Medical Examiner	an: To the best of my k On the basis of exam and manner stated.	knowledge, death ination and/or in	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occi	a, and due to the cau arred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
To ti To ti To ti	M	29b. Signature and title of certifier	المحمدايا	~	29c. License		i	d. Date signed (Month	n, Day, Year)
HV	40.	30. Name and address of person who comp	P21 /		Print) Tan street	r Bae	timore	nd 2	120/
St	ate	31. Date filed (Month Day Year)	32. Registrar's Si	nature	٧				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Darlene Renee Blackwell State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day July 29, 2009 1152 hrs Blackwell **Medical Examiner** Rene! Darlene 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Columbia Howard Howard County General Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours oreign Director Country) MD 214-68-4858 M 2X F 19 55 2 53 Yrs Usual Residence of Decedent 10d. Inside City Limits ì 10a, State 10b. County 10c. City, Town or Location Yes 2X No Columbia 28a-f show MD Howard or items 23a or 28a-f shomust be notified at once. 10e. Street and Number 10g. Citizen of What Country? 21045 õ Unit E 303 U.S.A. 5971 Millrace Ct. Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. XNever Married Yes 2X No Black after If Yes. Give Year Specify: Widowed 1 Divorced Yes 2X No specify: Examiner "natural" þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Dccupation (Give kind of work done 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 72 hours Completed during most of working life. DO NOT use retired) Johns Hopkins-Elementary/Secondary (0-12) College (1-4 or 5+) ment of Health and Mental Hygiene.

tant: If item 27 is marked other than "
or other traumatic event, the Medical 21215-0036 X-Ray Technician 12th grade 4yrs Bayview Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last Jewell Askew Harold Blackwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) B 3214 Dorithan Road, Baltimore, Md 21215 Jewell Blackwell-Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Arbutus Memorial Park 8/6/09 Arbutus, Other Specify Donation 5 nature of Funeral Service Lice see 22 Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, 21215 Part I. Ententhe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** Between Onset and /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial - transi Physician/Medical UNPENDED AMENDED The law requires that the death certificate be Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death Month Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 V No 9 Unknown 9 Unknown signed by the be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. <u>ج</u> No 3 Probably 4 ✓ Unknown Yes 2 Completed s been s 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy s certificate has b irector, page 2 sh Yes 2 ✔ No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Hospital: Other DOA Nursing Home 5 Inpatient 2 FR/Outpatient 3 this 1 🗸 Yes No 28a. Date of Injury (Month, Day,Year) 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 1 V Natural Yes 2 24 hours after death. Director: Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined (Specify) Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 2 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. July 30, 2009 30. Name and address of pers w o completed cause of death (Item 23a) 6 Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 Jack Titus MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 06 Taylor Barksdale Leola /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner btimos 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 578-34-3266 ge (In yrs. last birthday) **Funeral** Year Months Min 1 □ M 2 🕱 F 1922 S.C. Director Sept Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the fixed at a variant and an additional and the contract of the fixed at a second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second seco Baltimore Baltimore 1 ☐ Yes 2 No MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21207 USA 5203 Liberty Heights Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: Black þ 1 ☐ Yes 2 ☑ No Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Abacus Cleaning Custodian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Johnson David Ratliff Laura 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau 5203 Liberty Heights Ave, Balto., MD 21207 Ruby Stamper - Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 08-06-09 Baltimore 4 □ Ponation 5 □ Other (Specify) 22. Name and Address of Facility
March Funeral 21. Sign tur of Funeral Service Licensee Home West, Inc. 4300 Wabash Ave. Balto. 21215 23a. Par 1. Enter the in ease, or complications that caus shick, or heart failure. List only one cause on each The death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** em /Medical s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the attending physician and hed for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month in the past 12 months? Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an page 2 s has autopsy performe Yes 2 certificate 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2 No 2Ă ER/Outpatient 3 □ DOA ၉ 1 🔲 Inpatient this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated.

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

32 Aegistrar's

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Maryla		artment of H <i>rtificate of L</i>			iene <sub>eg. No.</sub> ?	9 24765
Dharis		1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month		3. Time of Death
Physici /Medio		Vernetta	Carrie		Braham		07	30 200	
Examir		4a. Facility Name (If not institution, give st	reet and number)			Location of Death		4c. County of	
		Manor Care Nurs				nsville			imore
Funeral Director		5. Social Security Number 6. Sex 1□	7. Age (In )	rs. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 03 25	Year)	9. Birthplace (State or Foreign Country) MD
pu »		Usual Residence of Decedent  10a. State 10b. County	100	City, Town or Lo	ocation				10d. Inside City Limits
aryla sho	2	,	100.						1 Yes 2 □ No
the M 28a-f	Director	MD NA  10e, Street and Number		Bdl	timore 10f. Zip Code		T 1	0g. Citizen of Wh	
with a or	Ö		4			1216			5 • A •
eath	era	2125 Allendale R	. Was Decedent Ever in	1 U.S. 13.			ecify Yes or No-		American Indian,
ING Z I Z I 3-UU30 be filed within 72 hours after death with the Maryland tital Hygiene. dother than "natural", or items 23a or 28a-f show event, in the filed Examination instituted	y Funeral	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 □Yes 2 No If Yes, Give		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 🍇 No	n, Mexican, Puerto Specify:	Rican, etc.)	Black,	White, etc. Black
Z1Z15-0U36 d within 72 hours aft glene. ar than "natural", or in the diest Exerti	ed by	3 X Widowed 4 □ Divorced  15. Decedent's Educa	Year or Dates:	16a. Dece	dent's Usual Occupa	ation		16b. Kind of Busin	
C iii 72	Completed	(Specify only highest grade	completed)	ı (Give	kind of work done d DO NOT use retired,	lurina most of work	ing		,
Z Z Z	E	12th grade	College (1-4or 5+)na		Housewit	fe		Ног	ne
other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, I	Maiden Surname)	
fryland A thould be filed and Mental Hygi marked other matic event, II	2	Claiborne Cochra	ne			Elizabe	eth Fer	rell	
S & B & S		19a. Informant's Name/Relationship (Type		19b. Maili	ng Address (Street &	and Number or Rur	al Route Number	r, City or Town, St	tate, Zip Code)
and 2 and 2 ealth a n 27 is	11 3	Phillip Braham S					Balt	imore,	Md 21216
es 1 es 1 es 1 es 1 es 1 es 1 es 1 es 1		20a. Method of Disposition	20l	<li>b. Place of Dispo cemetery, crea</li>	osition (Name of matory or other place	e)	Date	20c. Location - Ci	ity or Town, State
allimore, rmit. Pages 1 ar partment of Hea portant: If Item 3 y injury or other		1√2 Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Onation 5 ☐ Other (Specify)		ing Me	morial I	Park 8/6	5/09	Woodlav	wn. Md
baltimore, we permit. Pages 1 and Department of Health Important: If Item 27 any injury or other to once.		21. Signature of Funeral Service Licenses	2,~	2	2. Name and Address arch F/F	ss of Facility	8		
	M2 0	Munis	Da	43	00 Wabas	sh Ave,	Baltin	ore, Mo	d 21215
		23a. Par 1. Enter the dis-ase, or complice shock, or heart fail. e. List only one	ations that caused the decause on each line	eath. Do not en	ter the mode of dying	g, such as cardiac	or respiratory arr	rest,	Approximate Interval Between
Physician	8 1	Immedi e Cause (Final disease or condition	1	EIMER	25 D	EMENT	TA		Onset and Death
/Medical		resulting in death)	Due to (or as a cons				171		
Examiner		Sequentially list conditions, b.							
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tte be execusivisician and	E		Due to (or as a cons	sequence oi).					
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death certif	Physician/Me	in the past 12 months?	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time	etal death 3 l	☐ Ectopic pregnancy ☐ Other (specify)	4		23d. Date Monti	
. 0 00	ysic	1 ☐ Yes 2 ☒No 9 ☐ Unknown	9 Unknown	or doddin - 51					
that the ed by detail		Part II. Other significant conditions cont	ributing to death but not	resulting in the u	inderlying cause give	en in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?
uires uires sigr Id be	d by	HYPERTENSIVE	CARDIOVAS	GALAR	D15845	3	1 □ Y	es 2 No 3	□ Probably 4 □ Unknown
ecords, r.O law requires that the as been signed by th 2 should be detache	lete						24a. Was a	n 24h We	ere autopsy findings available
VILAI NECONAS, sician: The law requires the certificate has been signed inector, page 2 should be director.	Completed						autops perfor	sy pri- med? dea	or to completion of cause of ath?
		25. Was case referred to medical				OS Diago of Doot	1		□Yes 2□No
OI VITAI Physiclan: r this certifice ral director, p	Be c	examiner?	spital: 1 ☐ Inpatient 2	□ EP/Outpatio	nt 3 DOA Othe	26. Place of Deat		ence 6 ☐Other	(0
on or of of of of of of of of of of of of of	2:	27. Manner of Death	28a. Date of Injury	28b. Time o				ow injury occurred	
a fun	ţį	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year	r) Injury		(? Yes 2 □ No			
lor Attending Physician: Tafer death.  Director: After this certification by the funeral director, and on the funeral director, particularies.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp.	it home, farm, st	reet, factory, office		28f. Location (S.	treet and Number	or Rural Route Number,
s afte	Sert	4   Homicide	building, etc. (Sp	ecity)			City or Tow	n, State)	
To the Hospital or Attending Pl Within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral		(Check only 2 Medical Examine	clan: To the best of my er: On the basis of exan	knowledge, dea nination and/or in	th occurred at the tin	ne, date and place, pinion, death occur	and due to the or	cause(s) and man late and place, an	ner as stated. Indicate to the cause(s)
thin 2 the l	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c, License				(Month, Day, Year)
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H		30. Name and address of person who con				ince !	7000 50	155	1 Mp 2/136
Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature	MIER DI	7 7 1	トレーンノーで	NOTOWN	V /4-1126
Regist		AUG 0 4 200	9 Drewa	A. A	MIER DR				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** UFFINCTION 0000 Judith. JUI /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Months Days Hours M 8. Date of Birth (Month, Day, Year)
July 27,1945 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In vrs. last birthday **Funeral** Days 1 - M 2 X F 162-36-7908 64 Pennsylvania **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 1 ☐ Yes 2X No Director PA Dauphin Harrisburg 10g. Citizen of What Country? 10e. Street and Number 10f, Zip-Code 209 Francis L. Cadden Pkwy Apt 202 17111 United States of America · death \ Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give X 14. Race - American Indian, 11. Marital Status Black, White, etc e filed within 72 hours after d ul Hygiene. other than "natural", or iten 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed by 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) H. C. NYE Elementary/Secondary (0-12) College (1-4 or 5+) Administrative Assistant Contractor permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If item 27 is marked other 1 any injury or other traumatic event, the once. other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel J. Heffner Ellen F. Rogers ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 209 Francis Cadden Pkwy,Bldg 209,Apt 202 HBG, PA 17111 Harold Buffington (Husband) altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Woodlawn Mem. Garden Aug. 03,09 Harrisburg, Pennsylvania 1 Nurial 2 Cremation 3 N Removal from State 17109 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 2 Name and Address of Facility Miller—Dippel Funeral Home, Inc. 6415 Belair Rd.Baltimore, Maryland 21206 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final thoraco abdominal Physician MOUTH disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any teaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events septimized that increase in death), and Doe to (or as a consequence of) The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) physician Box 68760, Physician/Medical the signed by the attending phid be detached for use as i 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 page 2 should be 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed; certificate has 1 Yes 2 Z No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 1 Inpatient 3 🖺 DOA မှ After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: al or Attending P s after death. Il Director: After t 1 🖊 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 
Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date-filed (Month, Day, Year)

29b. Signature and title of certifier

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32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2009 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard County General Hospital Columbia Howard 8. Date of Birth (Month, Day, Year) November 5,1919 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1**₺** M 2□ F 89 Pennsylvania 206-01-3451 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hyglene.
ant: If them 27 Is marked other than "natural", or Items 23a or 28a-f show uny or other traumatic event, ith Medical Examine must be notified at 1 ☐ Yes 2XXNo Ellicott City Maryland Howard Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21042 U.S.A. 3910 River Walk Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Completed by 3 Nidowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Westinghouse Elementary/Secondary (0-12) 12 College (1-4or 5+) Manufacturing Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Victoria Kryszczak Walter Briski 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3910 River Walk Ellicott CIty, Maryland 21042 Cathy B. Teleky (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Columbia Memorial Park Clarksville, Maryland 8-6-2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Witzke Funeral Homes, 5555 Twin Knolls Road 21. Signature of Funeral Service License Inc. Columbia, Maryland 21045 23a. Art1. Enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 24 has resulting in death) /Medical Due to (or as a consequence of) Examiner aureu Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached to □Yes 2□No 9 HInknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes ours after death.

neral Director: After this certifical filled in by the funeral director, it Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1∐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only within 2 and manner stated. 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

5755 Cedar Lane Kim Gonlg 31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause

32. Registrar's Signature

of death (Item 23a) (Type, Print) Columbia, Maryland 21044

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2604

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Stella Ethe1 Bothe /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTI MORE HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea January 23, 9. Birthplace (State or Foreign Country) New York Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔽 F Months Days Hours 1925 145-14-5949 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exeminer must be notified at 1 ☐ Yes 2 ☑ No **Funeral Director** Halethorpe Baltimore Maryland death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21227 2805 Hoffman Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2√ No Specify þ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home <u>Homemaker</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Teche1 Mary Frederiksen ဂ္ Julius Walter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2238 Mount Hebron Drive, Ellicott City, Maryland 21042 Health a James H. Bothe/ Son Department of Health Important: If Item 27 any Injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition August 1, 2009 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State Balttimore, Maryland Metro Crematory, Inc. 5 ☐ Other (Specify) 4 Donation Ananca Heaston 22. Name and Address of Facilit Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo (or as a consequence of) Examine cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 PNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 4 🗂 Unknown 1 🗌 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page 1 ☐Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date sigged (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar

excaton Ave Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5 per Fh G895 9/14/09 TT
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2009 Month **Physician** BERNHARD AXEL BANG August 1, 1:29A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 13801 York Road #E13 Cockeysville Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 250 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Pay, Year) Jan 12, 1924 9. Birthplace (State or Foreign **Funeral** 1**X**XM 2□ F 220-18-<del>6350</del> 85 Jan Mary Tand Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or items 23a or 28e-f show the mast be notified at 1 ☐ Yes 2 No Directo Marvland Baltimore Cockeysville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13801 York Road #E13 21030 USA Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or Items 23 array or other treumatic event, Its Mentalcal Existing at marray. 12. Was Decedent Ever in U.S. Armed Forces? VXYes 2 ☐ No WW I I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 Yes XXNo Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Axel Frederik Bang Carol Millicent Klee ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Ann Bang 13801 York Road Cockeysville, Maryland 21030 Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or GreenMount Crematory | Aug 4 2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FMTTCHELL-WIEDEFELD FUNERAL HOME INC 21. Signature of Funeral Service License Jours 6500 York Road Baltimore, Maryland 21212 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications shock, or heart failure. List only one from that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner and Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 2 12 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 22 1 ☐ Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Cther: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Yes 2 PNo 2 2 ER/Outpatient 3 DOA 27. Manny of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Certification: Division the Hospitel or Attending 1 VNatural 5 Pending death. investigation 1 Tyes 2 No 2 Accident after death Director: 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a To the Funerel C 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

CRNHKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #7 &8 per Fh 9894 8/11/09 TT State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 29 Vear **Physician** Georgia LHA 2009 0600pm VIY /Medical 4a. Facility Name (If not had itution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner Gwynndale Baltimore Baltimore tvenue 5630 Date of Birth If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1927 **Funeral** 1 ☐ M 2 X F Min. Months Days Hours 128.30.082 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Department of Health and Mental Hygiene, instural, or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show any lipury or other traumatic event, the Madical Evantinar must be rediffied at once. Baltmore Baltimore MD 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Gnynndale Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Dio 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black \$ Specify: 3 Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mental Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) cola Tucker Otis Graves 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvin Avenue Catonsville MD 21228 homas Bland 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Windsor Mill, MD ing Memorial Park 08/06/09 21. Signature of Funeral Service Licensee shin C. Greeke Funeval SVC aughn C. Road Kandallstown MD 21132 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear dailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATHEROSCLEROTIC **Physician** HEAD /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ■ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Smith NO sbarah Burton Suite 203 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		,	1 - For Amend Registrar	State of Maryland / Item 23a per dr.,	Department of Health and 894,08704/09ahb Certificate of Death	Mental Hygier	ne No.2009 24771
	Physici	an	1. Decedent's Name (First, Middle, L	asi) Drinkley	-	1 - 1	Oay Year
-i	/Medic Examin		4a. Facility Name (If not institution, g		4b. City, Town, or Location of Dea	th diving	4c. County of Death
,			Bur Secu		Baldinune	city	NA
	Funeral Director		218-60-2899	Sex 7. Age (In yrs. last to 57	irthday) If Under 1 Year If Under 24 Hr.  Yrs. Months Days Hours Mir		9. Birthplace (State or Foreign Country)  1951 Hary and
	yland		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	wn or Location	•	10d. Inside City Limits
	ne Mar 8a-f sh zliffed	ector	MD NI	,A ,	Battimore		1 Pres 2 No
	with the	<b>Funeral Director</b>	851 Harlen	a Que	10f. Zip Code	10g.	Citizen of What Country?
	ems 2	ınera	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forcea?	13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - American Indian, Black, White, etc.
036	72 hours after death with the Maryland natural", or items 23a or 28a-f show disal Exambra must be positived at		1 ☐ Never Married 2  Married 3 ☐ Widowed 4 ☐ Divorced	1	1 □Yes 2 01No Specify:	,,	Specify: Black
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212	d within giene.	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	Bus Driver	A1	Transportation
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show with injury or other traumatic event, the Wedferl Exacting on the traumatic event, the Wedferl Exacting on the traumatic event, the Wedferl Exacting on the traumatic event, the Wedferl Exacting on the traumatic event, the Wedferl Exacting on the traumatic event, the Wedferl Exacting on the traumatic event, the Wedferl Exacting on the traumatic event, the Wedferl Exacting on the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event of the traumatic event event of the traumatic event of the traumatic event event of the	To Be C	17. Father's Name (First, Middle, La.		18. Mother's Na	me (First, Middle, Maid	
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	1 and 2 Health em 27 l		Margo Wright 20a. Method of Disposition	WITE IT	710 Thomas Ave of Disposition (Name of	Bathim Date 20c.	Cocation - City or Town, State
mor	Pages ent of nt; If its ry or o		1 Surial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	ery, crematory or other place) Zion Cemeter 4 7	29/2009 F	Saltimore MD
Baltimore,	permit. Pages 'Department of H Important: If ite any injury or of	li	21. Signature 1 Femeral Service Lic	2 1	22. Name and Address o Facility	owell F	uneral Hong
<b>6</b>	20 E # 9	10	Ming)	- finalle	- 14600 Liberty 1-	leights Ai	
	Physician	F 108	shock, or heart failure. List on Immediate Cause (Final	mplications that caused the death. Do	o not enter the mode of dying, such as cardio Cardiomy		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence			
	Examiner	<u>.</u>	Sequentially list conditions,	b. Due to (or as a sensequence	ertension		
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Box	eath certifi attending for use as	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea			23d. Date of delivery  Month Day Year
P.O.	the deay y the and ched for	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		Worth Day Total
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of	Physi or this caral dire		1 ☐ Yes 2 ☐ No  27. Manner of Death	Hospital: 1 Inpatient 2 ER/C	Outpatient 3 DOA Other: 4 Nursing Time of 28c. Injury at	Home 5 TResidence	
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Division of Vital Records,	al or Atten after deatl Director: d in by the	Certification: To	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		farm, street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
1	To the Hospital or Attending Physician: The I within 24 Hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one)  1 ☐ Certifying I 2 ☐ Medical Ex-	Physician: To the best of my knowled aminer: On the basis of examination a and manner stated.	ge, death occurred at the time, date and pla and/or investigation, in my opinion, death occ	ce, and due to the cause curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
1)	To the within 2 To the comple	Mec	29b. Signature and title of certifier	and marmer stated.	29c. License number	29d.	Date signed (Month, Day, Year)
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	<b>5 5 6</b> 8		Laur	-, no	1008111	Jy	114 33 1 309 d
	7 × × 0			o completed cause of death (Item 23a		J.	By 22, 2009
	Sta	te	30. Name and address of person who Day I eve Polo was 31. Date filed (Month, Day, Year)  AUG 0 4 200	32. Registrar's Signature		Street K	Buldinne, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 7:55 AM M JULY 2009 31 WILLIAM ARNOLD BISHOP /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford 315 Willrich Circle Forest Hill If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Months 1 🙀 M 2 🗆 F 75 218-32-6295 **Director** Maryland Sept. 18, 1933 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show notified at 1 ☐ Yes 2 No Forest Hill Director Harford Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene.
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Department of H
Important: If ite
any injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 8/1/2009 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Supple ige Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, 23a. Part 1. Enter the disease, or complications that caused the ceath. shock, or heart failure. List only one cause on each line Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sel gum sto T disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Liecas of Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical been signed by the attending p should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy 2 No 2 No 1 □ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Yes 2∐No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural July 3/2009 07554 M 1E 28e. Pluce o Injury - At home, farm, street, factory, office building, etc. (Specify) 10755A after death.

I Director: A
d in by the fu 1 ☐ Yes 2 No + 10 Sho 2 Accident Sucdeaun 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 315 UNIVED CINCLE FORST HILL MD 21050 3 Suicide determined 4 Homicide within 24 hours aft To the Funeral Di completely filled in Home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

State Registrar 29b. Signature and title of certifie

30. Name and address of person

the

29c. License number

29d. Date signed (Month. Day. Year)

and manner stated.

ello

se of death (Itam 23a) (Type, Print)

MD 32. Registrar's Signature

amend #18 Per FH G894 8/11/09 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Anna M. Bush 1\_ 10:35A <sup>™</sup> August 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 M 2 XF 12/18/1934 **Director** 74 Pennsylvania 186-26-9451 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City. Town or Location 10a State 10d. Inside City Limits 28a-f show 27 Is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Widcal Evening and Director 1 XYes 2 □ No Baltimore MD n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2820 Huntingdon Avenue 21211 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No White Completed by Specify. 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Earnings Record Coder Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (Fixtal Inches Surname) Be Pages 1 and 2 should be in ment of Health and Mental ant: If item 27 Is marked o Anna C. Hulthouse Richard N. Greenholt ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr once. Cheryl Bush / Daughter 3115 Aspen Ct., Baltimore, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 8/3/2009 Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ovarian /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 ☐ Other (specify) has been signed by the e 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗆 Yes 20 1 ☐Yes 2 ☐ No this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 Inpatient ၉ 2 ER/Outpatient 3 DOA 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔀 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause 31 Date filed (Month, Day, Year) State 04 Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ FOF	partment of Health and N	∕lental Hygier	ne	01-7-1
				ertificate of Death	Reg. N	vo.2009	24/14
	Physicia	an	Decedent's Name (First, Middle, Last)		Date of Death     Month	Day Year	3. Time of Death
	/Medic		Leora Francis Calvin		July 1	9 2009	2:06 A M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Southern Mary and Medical Center  5. Social Security Number 6. Sex 7. Age (In yrs. last birthd)	av) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Prince (	nplace (State or Foreign
	Funeral Director		227-40-8802 1 M 28 F 83 Yrs	Months Days Hours Min.	(Month, Day, Yea	ar) Cou	Sintry)
			Usual Residence of Decedent				
	rylan	_	10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	8a-f s	Director	VA Brunswick Kawli				1 ☐ Yes 2 X No
	a or 2	Ö	10e. Street and Number	10f. Zip Code		Citizen of What Cou	intry?
	72 hours after death with the Maryland "natural", or items 23a or 28a-f show "Ifon Experient must be notified at	Funeral	7642 Lew Jones Koca	3. Was Decedent of Hispanic Origin? (Sp		SA 14. Race - Ameri	ican Indian
	fter d	Fun	11. Marital Status  12. Was Decedent Ever in U.S. 1 Armed Forces?  1 Never Married 2 Married 1 Yes 2 No. 2	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
93	urs a	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 MENo Specify:		Specify: 3	lack
5-003	72 ho	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (G.	cedent's Usual Occupation	ina 16b.	Kind of Business/Ir	ndustry
121	within 72 iene. than "na'	mp	Elementary/Secondary (0-12)   College (1-4or 5+)   ,	ive kind of work done during most of work e. DO NOT use retired)		1 0	. \
7	be filed within 72 ho ntal Hygiene. d other than "natul event, Ib III dical		17. Father's Name (First, Middle, Last)	Worker 18 Mother's Nam	e (First, Middle, Maid	od Manag	gement
au		Be C			le Stev		
Maryland	2 should and Men Is marke aumatic	₽	19a. Informant's Name/Relationship (Type. Print) 19b. Mi	ailing Address (Street and Number or Ru	ral Route Number. Cit	tv or Town, State, Zi	ip Code)
	2 c z s		James H. Calvin-husband 76	42 Lew Dores Rd	, Rowli	ngs. VA	23876
altimore,	- I 2 2 €		20a. Method of Disposition 20b. Place of Dis	sposition (Name of	Date 20c.	Location - City or T	own, State
Ē	m + = 0		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Wis Family Cem. 07-2	5-09 R	awlings	.VA
<u>a</u>	permit. Pag Departmen Important: any injury once.		21. Si native of Funeral Service Liganse	ivis Family (em. 172) 22. Name and Address of Eacility 22. Name and Address of Eacility 23. Name and Address of Eacility 20. Worker	Commun	ity FUNELA	of ASKETA
n	20 E 2 3		Marken (1	1206 W. WORRS	AUE		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	1 DISEA	G-6		Oliber and Death
	/Medical Examiner		Due to (or as a consequence of):	1			
		er	Sequentially list conditions, b. Use to (or as a consequence of):	m 3 Kung			
(	d d ansit	Examiner	Sequentially list conditions, if any, reading to firm cause. Enter Underlying Cause (Disease or injury that initiated events			1	
o,	cate be executed physiclan and the burial-transit	Еха	resulting in death) Last  Due to (or as a consequence of):				
09/8	ate be hysici he bu	dical	d				
	ertific ling p e as t	a)	IF FEMALE:				
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	he de the a	Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)			
<b>J</b> .	that t		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
g	puires n sign lid be	Completed by	Alghernek Deminti	7	1 ☐ Yes	2 ☐ No 3 ☐ Pro	obably 4 🔄 Unknown
ဝ္ပ	s bee	lete	O .		24a. Was an	24b. Were aut	topsy findings available
ř	The la	E O		A	autopsy performed 1 □ Yes 2 □	? death?	ompletion of cause of 2 ☑ No
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<u> </u>	ttend death. tor: / the fi	cati	2 Accident investigation 3 Suicide 6 Could not be 380 Place of Injury. At home farm	M 1 Yes 2 No	200 1		
DIVISION	l or A after ( Direc	Certification: To	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	and Number or Hui ate)	rai Houte Number,
/	spital		29a. Certifier 1 Certifying Physician: To the best of my knowledge, do	eath occurred at the time, date and place	, and due to the cause	e(s) and manner as	stated.
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending it completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/o and manner stated.				
/	Vithi Comp	ž	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	n, Day, Year)
			115 tello	D19889	Tu	1/2 19-	09
			30. Name and address of person who completed cause of death (Item 23a) (Type	pe, Print)	( F -		
	Sta	to	31. Date filed (Month, Day, Year) - 32. Segistrar's Signature	1 JOHINER TO HUL	) t	06 20	00 3 4
	Sta Registra		AUG 04 2009 Seneur B.	Southern Auc			
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# Baltimore, Maryland 21215-0036

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		•	For State Registrar							Death			Reg. No	00	0 0	91	775
	Physicia		1. Decedent's Name (First, Mic		C. di	ase						Date of Dea	ath Da		Year 09	3. Time	
-	/Medic		4a. Facility Name (If not institu		treet and number)	1430	1	4b. City	, Town, or	Location of D	Death	1001	4c.	. County o			•
	LXummi	٠.	Univ. of N	lanta	nd Medi	ial (	enter		Bal	Himore	2			N	IA		
	Funeral		5. Social Security Number	6.≸ex	7. Ag	e (In yrs. I	ast birthday)	If Unde	er 1 Year	If Under 24	Hrs. 8. [	Date of Birt Month, Da	th y, Year)		9. Birthpla Countr	ice (State	or Foreign
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and	M.	1	Usual Residence of Decedent  10a. State 10b. Cour	nty		10c. City	, Town or Lo	cation							100	d. Inside	City Limits
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h with	23a o		307 North B	ruce	Street				212	23				U.	S.A.	•	
deal	ems	Funeral	11. Marital Status un		2. Was Decedent Armed Forces?		S. 13.	Was Dec	edent of H	ispanic Origin an, Mexican, P	? (Specify Puerto Rica	Yes or No n, etc.)	-		- America		
36 afte	or it	by Fu	1 Never Married 2 N		1 □ Yes 2 ▼ If Yes, Give	No		1 □ Yes		Specify:				Specify:	В1а	ack	
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و ا	al Hyg	Be C	17. Father's Name (First, Midd	le, Last)						18. Mother's	Name (Fil	st, Middle,	Maiden	Surname	)		
Val	Ment arked atic e		Kevin Chase	Sr.						Elle	n Re	dd					
Maryland d 2 should be file	ls ma		19a. Informant's Name/Relation	, , , , ,	ŕ			9		and Number o			er, City	orTown, S It•im o	State, Zip (	ode) Md	21223
and and	it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, It = W. died Exanimet must be notified at		riffany Harr	ison			307			ruce		- 1		ocation - C			
Baltimore,	nt of h		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crematic		unk emoval from State	206. P	lace of Dispo emetery, crea	natory or	other plac	rk	Date	unk		Ltimo			
ir Pa	irtme irtant njury		4 ☐ Donation 5 ☐ Other  21. Signature of Funeral Serv	. ,	Λ   /	1	2	2 Name	and Addres	es of Facility			Бал	LLIM	ore,	MG	
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Ph	ysician		shock, or heart failure. I	ist only on	e cause on each II	id T	V r			. 41						Onset an	d Death
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J. B	##	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Į	Due to (or as	a consequ	uence of):										
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687 tificate	attending physi	edic		- 0	·												
Box eath cert	anding use a	N/M	IF FEMALE: 23b. Was decedent pregnant	2:	3c. If yes, outcome	of pregna	incy	المسادة	pregnanc					23d. Date	of deliver	У	
Geat	e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No		4 Pregnant a			Other (		У		-		Mon	oth [	Day	Year
P.O	d by the	Physician/Medi	9 Unknown									00 0144			le color de Alexa		f do ath?
S,	signed be de	þ	Part II. Other significant cond	itions con	tributing to death b	ut not rest	ulting in the u	inderlying	cause giv	en in Part I.		23e. Dig t	•	use contri			Unknown
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Division of Vital Records, or Attending Physician: The law requires the	er de: recto by th	Certification: To		ıld not be ermined	28e. Place of Inj building, et	ury - At ho	me, farm, st	reet, facto	ry, office		28f.	Location (	Street a	nd Numbe	er or Rural	Route N	ımber,
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بع ا	≥ ¥ 8		) Alania		A.	12				4			T		05	- 1	2009
	d		30. Name and address of pers	son who co	mpleted cause of	leath (Iten	n 23a) (Tvpe	Print)		020			U	<u></u>	d		
	4		11.	nester	22 So.		Greer		st.	Balti	more	M	)	21	201		
	Sta	0.1	31. Date filed (Month, Day, Ye	ar)	32. Registr	ars Signa	ture d	b	arka	/		1		-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Ethel Carlies /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner NA more G If Under 24 Hrs Age (In yrs. last birthday) 5. Social Security Number 1 Year Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Months Hours 91 SC 214-24-9709 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, Ite Modical Examiner must be rediffed at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Catonsville 1 □Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1701 Edmondson Avenue 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. African 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify: ģ <sup>Specify:</sup>American 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry Unk . 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) Unk. 17. Father's Name (First, Middle, Last) UNk. 18. Mother's Name (First, Middle, Maiden Surname) Ida Vines 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD3300 N. Ridge Road Apt.#235 Ellicott City Alisa Chernack 20a. Method of Disposition
1 ☑ Borial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Mt. Zion Cem. 08-01-09 Lansdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home F.A. 21. Signature of Funeral Service License 638 N. Gilmor Street Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to for as a nonsequence off aate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) CHRL/E) FTHEL Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 2 No 2 1 Tes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 □ DOA Certification: To 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 □Yes 2 □No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. caj (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medi 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30 Name and address of person ho completed cause of death (Item 23a) (Type, Print)

State Registrar 10

4 2009

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar Certificate of Dea	-	Reg. No. 2009	24777
	Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of De Month.,-	eath Day 1, 200	3. Time of Death
	/Medic Examin	al	Charlotte Elizabeth DeAtley  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Locati		4c. County of Deat	
-	LXdiiiii	e.	Saint Joseph Medical Center	Towson		timore
	Funeral Director		5. Social Security Number  220-86-5385    Continue	nder 24 Hrs. urs Min. 8. Date of Bi (Month, D Oct. 1	rth ay, Year) 9. Birt 7, 1916 Mar	hplace (State or Foreign unity) yland
	yland how		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Ba-f s	ecto	MD Baltimore Parkville		10 000	1 □Yes 2 No
	ath with t	eral Dir	10e. Street and Number  1927 Mountain Avenue  10f. Zip Code  21234		10g. Citizen of What Co USA	
9600	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination to other traumatic event, the Medical Examination to other traumatic event.	d by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No  1 □			
21215-0036	vithin 72 h sne, <b>.han "natu</b> v Medice	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  Homemaker	most of working	16b. Kind of Business/  At Home	ndustry
d 2	filed v I Hygie other ent, It	Be Co	12	Mother's Name (First, Middle		
ylan	Menta Menta arked artic ev	10 B	George A. Clayton	Della Y. Rile	∋y	
, Maryland	and 2 sho ealth and n 27 is m		19a. Informant's Name/Relationship (Type. Print)  Connie Colleran—daughter  19b. Mailing Address (Street and Nu. 1927 Mountain Av. 1927 Mountain Av. 1927 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mountain Av. 1928 Mo			
Baltimore,	. Pages 1 tment of He tant: If iten jury or oth		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cametery, crematory or other place)  1 Removal from State  4 Donation 5 Other (Specify)	Aug. 4, 2009	Baltimore,	Maryland
Ball	permit Depar Impor any In		21. Signature of Funeral Service Licensee  22. Name and Address of Five Funeral and Cremation	Chapel <sup>880</sup> Services	Harford Ro Parkville,MI	ad 21234
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.	h as cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
in the	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. INTESTINAL INFARCTION Due to (or as a consequence of):			DAYS
	Examiner					
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Entire Underlying Cause (Disease or injury that initiated events c.	1		
0,	e exectand and and rial-tra		that initiated events resulting in death) Last			
68760,	rtificate be executed ng physician and as the burial-transit	dical	d			
	ath ce	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of del Month	ivery Day Ye <b>a</b> r
P.	uires that the de signed by the a d be detached f		9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in P	Part I. 23e. Did	tobacco use contribute to	the cause of death?
Records,	quires t	d by			Yes 2X No 3 Pr	obably 4 🗆 Unknown
eco	e law requir has been s je 2 should	Completed		24a. Was		topsy findings available
a B	: The licate ha	Com		perf	ormed? death?	2 □No
Vital	Physician: The this certificate al director, pag	Be c	examiner?	Place of Death (Check only		
	ding Phy h. After this funeral d	iii	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	Nursing Home 5 Res	how injury occurred	city)
Division	Attending or death. ector: After by the funer	catic	2 Accident investigation M 1 Yes 2			
Div	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Certification: To	4 Homicide determined building, etc. (Specify)	City or To	(Street and Number or Ru wn, State)	
	e Hosp 24 ho e Fune	Medical	29a. Certifier  (Check only one)  1	ite and place, and due to the death occurred at the time	e cause(s) and manner as , date and place, and due	s stated. to the cause(s)
	70 th withir Comp	Me	29b. Signature and title of certifier  Helou M. D. 29c. License numb		29d. Date signed (Monta	
	0/		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		August 1	12001
	In		ABDALLAH J. HELOLA M.D., 7601 OSLER DRIV	VE, TOWSON,	MARYLAND	21204
	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signiture			

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2000

		for State Registrar					rtificate of			Re	g. No.	_ U U J	64110
Dhyaiai		1. Decedent's Name (First, M	iddle, Last)							ate of Death Month	Day	Year	3. Time of Death
Physici /Medio		JAMES	EDWA	RD DO	ZIER				A	ugust	2	2009	12:55p M
Examin		4a. Facility Name (If not institu	ution, give st	reet and numb	er)		4b. City, Town, o	or Location o	f Death		4c. Cou	nty of Death	
		JOSEPH RICHI					BALTIM					N/A	
Funeral		5. Social Security Number	6. Sex	7. M 2□ F	Age (In yrs. la		If Under 1 Year Months Days		24 Hrs. 8. [ Min(	Date of Birth Month, Day, C. 26	Year)	Couin	lace (State or Foreign
Director		217-38-9274		WI ZUI	6	6 Yrs.	]		DE	26	1942	SOUTH	"CAROLINA
pur M		Usual Residence of Decedent 10a. State 10b. Cou			10c. City	, Town or Le	ocation					1	0d. Inside City Limits
aryk sho	5				100.00,	,							1⊈Yes 2□No
he M	Director	MARYLAND N/ 10e. Street and Number	Α				BALTIMOF	(E		10	a Citizen	of What Coun	try?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Evaniner roust by notified at once.								_					, .
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er de item	Funeral	11. Marital Status		2. Was Decede Armed Force 1 ∐Yes 2	es?	5.	Was Decedent of I If Yes, specify Cub	an, Mexican	, Puerto Rica	n, etc.)		Black, White, 6	
s aft	by F	1 X Never Married 2 ☐ I		If Yes, Give Year or Date			1 □Yes 2 🔯 No	Specify:			Spe	ecify: BLA	ACK
tura					,5.	16a. Dece	edent's Usual Occu	pation		1	6b. Kind o	f Business/Inc	dustry
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Hyg Hyg ent,		17. Father's Name (First, Mid	dle, Last)						er's Name (Fit	st, Middle, M	laiden Suri	name)	
ced c	To Be	MURRAY DOZIE	P.					CHR	ISTOLA	DOZIE	R		
mar mat	F	19a. Informant's Name/Relat		e. Print)		19b. Mail	ing Address (Stree					wn, State, Ziç	Code)
Ithar 27 is 27 is		Nadine Dozie:					Manning S						
1 an Hea Hea tem 3	-	20a. Method of Disposition	70100	<u> </u>	20b. P		osition (Name of matory or other pla		Date			on - City or To	
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		23a. Part Frier the disease	7				206 W NO			spin tory arre	oft.		Approximate
		shock, or heart failure.	List only one	cause on each	h line.	i. Do not ci	14	11	MAT	K.J.	/	/	Interval Between Operat and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a.		0/11	96	W, W/	1//	11/01	5/11	111	46	LIJ W
Examiner			-	Due to (or	a a consequ	ience off:	5 80 11				reg		
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atter for u	Physician/	in the past 12 months?	·		th 2□Feta nt at time of d		☐ Ectopic pregnan ☐ Other (specify)	ncy	_			Month	Day Year
y the ched	ıysi	1 □Yes 2 □No 9 □ Unknown		9 🗌 Unknov									
ned b deta		Part II. Other significant cor	ditions cont	tributing to dear	th but not resu	ulting in the	underlying cause gi	iven in Part I		23e. Did tob	acco use	contribute to t	he cause of de ?
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has Je 2	뮱	WARTE	5/							autops	v	prior to co death?	empletion of cause of
icate h r, page										1 □Yes 2	Mo	1 Yes	2 No
r this certific ral director, I	Be	25. Was case referred to the examiner?		ospital:			01	thor:	of Death (C			/	to lace of
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24 hours afte Funeral Dir tely filled in				1				P. data	10	de la Maria			-1-1-1
Fune Fune tely f	ical	(Check only 2 Med	lifying Phys lical Examin	er: On the bas	is of examina	wledge, dea tion and/or	ath occurred at the investigation, in my	time, date a opinion, dea	nd place, and ath occurred a	aue to the c at the time, d	ause(s) an ate and pla	a manner as : ace, and due t	stated. to the cause(s)
within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use	Medical	one) 29b. Signature and title of ce	rtiffer /	and manne	i stated.		29c Licer	nse number		2	9d. Date s	igred (Month,	Day, Year)
within 2 To the comple		29b. Signadire and little of Ce		1/200	141)	ı	77	120	10	-	PI	1/10	1
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	ļ.,	30. Harrie and address of the	who co	leted cause	of death (Iten	1 23a) (Type	, Print)	rlas	4	Anh	41	1911	21010
		31. Date filed (Month, Day,	ear)	00 Pa	gistrar's Signa	() / //	I CHOM,	110	114	141	01/	14	1049
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#1 per MD g894 8/24/09 TT Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Michael A. Dula, Sr. Matthew A. Dula, Sr 2. Date of Death 3. Time of **953**. Month **Physician** 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N, **Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days NC 245.92.2330 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10c. City, Town or Location "natural", or items 23a or 28a-f show Parkville 1 ☐ Yes 2 No Baltimore permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sl any injury or other traumatic event, the Medical Examiner must be notified it MD **Funeral Directon** 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number Maidbrook 9900 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Hack Specify: ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore Countr Police 12-th grade 2 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willie Nelson Mae Lee Lma 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Prin Matthew Dula, Jr. 1600 Humble Street Achboro, NC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07 09 limonium 22. Name and Address of Facility augn C. Greene Funeral 21. Signature of Funeral Service Licensee Vaushr 8 Liberty Road Randallstown MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear 141 ure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of signed by the attending physician and ald be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy Month Day Year filled in by the funeral director, page 2 should be detached for in the past 12 months? 5 Other (specify) 1 Yes 2 9 Unknown 2 No Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate has performed? 1 X Yes 1 🗌 Yes 2 🗌 No 2 🗌 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 4  $\square$  Nursing Home Hospital: 2 ER/Outpatient 3 DOA 6 🗌 Other (Specify) 1 Inpatient 5 Residence ည 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 Pending investigation 1 Tes 2 🗌 No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Les-000 person who completed cause of death (Item 23a) (Type, Print) 30. Name and a 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Amend 20b-c, Perint in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9:02 pm **Physician** 2009 Donald J. Duncan July 28 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** NATIONAL INSTITUTES OF HEALTH BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☑ M 2 ☐ F Director 474-41-0113 12/5/1974 Jamaica Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Markeal Examinat must be notified at 1 ☑ Yes 2 ☐ No Director GA Paulding Powder Springs 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 30127 287 Grandview Circle Funeral Jamaica Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ∐Yes 2 TNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 □Yes 2 🙀 No Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Pinkerton and Laws Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ MacDonald Duncan Adassa Barrette ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 287 Grandview Circle, Powder Springs GA 30127 Eboney Reynolds-Duncan/wife Baltimore, 20b. Place of Disposition (Name of Me topogo by realing or other pla 20a. Method of Disposition August 12, 2009 Alexandria, VA 1 ☐ Burial 2 🖺 Cremation 3 ☐ Removal from State uneral Home 8/15/2009 | Marietta, Georgia 4 □ Donation 5 □ Other (Specify) Crematory, The 10/13/2007 American Home 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licenses 4217 9th St NW Washington DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final VEN TRICULAR CHYCAKDIA **Physician** minute disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events conditions indextible act Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the humal-transit resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.0. 1 Tyes 2 No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No Division of Vital 2 □ No 1 ☐ Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Jopital C.
4 hours after dec.
4 meral Director: After a by the fer 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month. Day

Year)

of death (Item 23a) (Type, Print)

0101243203

10 CENTER DRIVE, BETHESDA,

MARYLAND 20892

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19a, perINF, G895, 972709, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1225 PM **Physician** 2009 Easley Gertrude /Medical 4b City, Town or Location of Death County of Death 4a. Facility Name (If not institution, give street and number) Examiner AIR HEALTH and Rehabilitation ( Be AIR If Under 1 Months Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2X F Days Hours Min. Va 220-20-4767 86 10-6-1922 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 XYes 2 No Director Md Baltimore N/A with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code o e ns 23a ( must b 21206 4916 Crenshaw USA by Funeral Apt F Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or Items 23
Inty or other traumatic event, the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black Specify 3€Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Baltimore City Elementary/Secondary (0-12) Cafeteria Aide Public Schools 10th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stephen Gregory ပ Polly Eldridge 19a Volume 1 Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21040 Vernal N. Gregory-Son 1306 Harford Square Dr Edgewood, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages
Department of I
Important: If Itt
any injury or o
once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 8-10-2009 Owings Mills, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March East F/H ) and 1101 E. North Avenue Balto, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** erebrovascul ac /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Completed by Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month 4☐Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has be lirector, page 2 s autopsy To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 20 No 1 Inpatient 2 ER/Outpatient 3 DOA ို 1 ☐ Yes this uneral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation within 24 hours are. Control of the Funeral Director: After To the Funeral Director: After To the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific August 3, 2009 006398 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Benjamin Lee, no 669 Revolution St , Havrede Grace, MD 21078 Revolution 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 4 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 29 Month 07 P M George Leonard Fischer 09 5:57 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death HOWARD 6160 Rockburn Hill Road Elkridge 9. Birthplace (State or Foreign Country) New Jersey If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Min. Months 1 🔀 M 2 🗆 F 12-03-1939 131-30-4118 69 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No MD Howard Elkridge 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6160 Rockburn Hill Road 21075 United States 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No If Yes, Give 1 Never Married 2 Married 1 ∐Yes 2¥∭No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Executive DCA Foods 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George B. Fischer Mary Owens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Clare V. Fischer- wife 6160 Rockburn Hill Rd., Elkridge, Maryland 21075 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1ÆBurial 2 ☐ Cremation 3 ☐ Removal from State St. Augustine Cem. 08-03-09 Elkridge, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP., Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Colon Etastatic disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leaving to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical

**Physician** /Medical Examiner

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traun once.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

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d 2 should be filed within 72 hours after death with the Maryla th and Mantal Hygiene.
77 is marked other than "natural", or items 23a or 28a-f shov traumatic event, its its its its incommitted in the interest of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribution of the contribut

Baltimore, Maryland 21215-0036

Examine burial-tran and attending physician for use as the buria Physician/Medical signed by the a \$ certificate has been si rector, page 2 should ! Completed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, F. Be Certification: To

The law requires that the death certificate be executed

Box 68760,

Division of Vital Records, P.O.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

examiner's

27. Manner of Death

1 Natural
2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

1 Yes 2 No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

suite 205 harles

and manner stated.

31. Date filed

5 ☐ Pending investigation

6 Could not be determined

32. Registrar's Si

M.D.

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 3:28 PM Francis Xavier Ford 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Hospital Belair If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
December 14,1927 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours Min Maryland 220-20-0497 81 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Department of Health and Mental Hygiene, important; or Items 23a or 28a-f show amportant; if item 27 is marked other than "natural", or Items 23a or 28a-f show amportant; if item 27 is marked other than Medical Expression of the redifficed at once. 1 ☐ Yes 2 ☑ No Director Maryland Harford Belair 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 700 Heritage Lane #E 21014 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XXYes 2 ☐ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 ▼ No Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Mooney John Ford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) James M. Ford (Nephew) 1713 Abelia Road Fallston, Maryland 21047 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Crestlawn Memorial Gardens 8-5-2009 Marriottsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Moneral Service License 22. Name and Address of Eacility Witzke Funeral Homes, 5555 Twin Knolls Road Inc. Columbia, MD 21045 Approximate Interval Between Onset and Death 23a. Parv. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** hours /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and burial-tran Due to (or as a consequence of): certificate has been signed by the attending physician rector, page 2 should be detached for use as the buria P.O. Box 68760 Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ■ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2. No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**4**(No 1 ☐ Yes Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natoral 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifie Medical (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July D0053568 osapeako 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Day, Year) State AUG 0 4 2009 2 reune Registrar parke

DHMH 17 Rev 1/2001

2009

Division of Vital Becords P.O. Box 687607

		Please Type or Print in Black In State of Maryland / Dep					
	_1		rtificate of Death	Re	eg. No. 2 0 0 9	21, 7.85 3. Time of Death	
Physicia /Medica	n al	1. Decedent's Name (First, Middle, Last)  Leroy H. Fisher Sr.		2. Date of Death Month August	3 2009 Year	7:00a M	
Examine	_	4a. Facility Name (If not institution, give street and number) 10 Armor Court	4b. City, Town, or Location of Death Middle River		4c. County of Death Baltimore		
Funeral Director		5. Social Security Number 6. Sex 1 $\square$ 40 6 2 1 $\square$ 7. Age (In yrs. last birthday 1 $\square$ 7. Age (In yrs. last birthday 1 $\square$ 7. Age (In yrs. last birthday 1 $\square$ 7. Age (In yrs. last birthday 1 $\square$ 7. Age (In yrs. last birthday 1 $\square$ 7. Age (In yrs. last birthday 1 $\square$ 8.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Sept. 2	Year) Cour	place (State or Foreign htry) PA	
		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	ocation			I0d. Inside City Limits	
Maryla a-f sho	ctor	MD Baltimore Mide	dle River			1 □Yes 2 No	
with the	<u> </u>	10e. Street and Number 10 Armor Court	10f. Zip Code 21220	1	0g. Citizen of What Cou USA	nuy?	
	큔	11. Marital Status  1 □ Never Married 2 □ Married If Yes 2 □ No If Yes 2 □ No If Yes 3 □ No If Yes 3 □ No If Yes 3 □ No If Yes Give	. Was Decedent of Hispanic Origin? (Spirityes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: W		
hours a	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	edent's Usual Occupation		16b. Kind of Business/Ir		
thin 72 ne. nan "nat	Completed	(Specify only highest grade completed) (Giv	e kind of work done during most of work DO NOT use retired) lder	king	Steam Fit	ters	
filed wi Hygier Sther th	Be Cor	12th  17. Father's Name (First, Middle, Last)	18. Mother's Nam		Maiden Surname)		
Mental Mental arked o	To B	Robert Altvator  Margaret Pace  19a Informant's Name/Belationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
od 2 should the and 27 is m		19a. Informant's Name/Relationship (Type. Print)  Juanita Coleman/step-daughter	417 Kennard A				
ages 1 ar ent of Hea it: If item y or othe		20a. Method of Disposition 20b. Place of Dis	position (Name of ematory or other place) awn Cemetery 8/0		20c. Location - City or T Baltimor		
permit. Pages 1 and 2 should be filed within 72 hours: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; any injury or other traumatic event, the Medical Exagnice.					Ave. Bal		
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Connelly Funeral Home of Essex 21221  Approximate Interval Between Onset and Death					
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. TRUNING U  Due to (or as a consequence of):	CANCER				
Examiner	_	Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):					
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be executed sician and burial-transit							
oo/ rtificate ng phys	<b>Jedic</b>	IF FEMALE:					
UNISION OT VITAI RECORDS, F.O. BOX OOF  To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the temperature.	Physician/Medica	23b. Was decedent pregnant  1  Live birth 2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of del Month	ivery Day Year	
s that the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?					
ecords, law requires t as been signe 2 should be c	eted k	Prostate CANCER, Diabetes Mellitus 1 Yes 2 No 3 Probably 4 Unknown Type II Hypentensive Canoid Asculta Disease 24a. Was an autopsy findings available prior to completion of cause of death?					
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VITAI /sician: T s certificat director, pa	o Be	25. Was case referred to medical examiner?  1   Yes 2 1   No   Hospital: 1   Inpatient 2   EP/Outpatient 3   DOA   Other: 4   Nursing Home 5   Defection Residence 6   Other (Specify)					
ding Phy h. After thi funeral o	tion: T	27. Manner of Death  1					
DIVISION OI  I or Attending Phy after death. Director: After this d in by the funeral of	Certification: To	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (S City or Tov	Street and Number or Ri vn, State)	ural Route Number,	
Hospita 24 hours Funeral etely filled	ledical C	29a. Certifier (Check only one)  Check o					
To the To the To the Complex	Me	29b. Signature and title of certifier	29c. License number 20017148	>	29d. Date signed (Mont		
6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) \$610-13 W. 180N TOIN) LOAP, BOLTIMORE, MARYLAND 21220					
Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	h had the				

**Physician** /Medical **Examiner** attending physician

Vital

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Hospital or Attending Physician;

within 24 hours a er dear To the Funeral Director

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**Physician** 

/Medical

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**Funeral Director** 

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Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Medical Experiment must be notified at once.

Pages 1 and 2 sment of Health an

Baltimore, Maryland 21215-0036

2

Be Completed

Certification: To

Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

6 Could not be determined

Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier wa Grimaldi, MD

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LISIT GRIMALDI GOO CATON A

900 CATON AVE BALTIMORE MO

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0 1, 2009 10:45AM UP August /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Parkville
| Frunder 1 Year | Frunder 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May 5, | Baltimore Oakcrest Care Center 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 ☐ M 2 F 88 Maryland Yrs Director 219-07-4133 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Examinist must be rediffed a once. 1 ☐ Yes 2 No Director Maryland Baltimore Parkville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Broadview Bldg. 21234 U.S.A. 8810 Walther Blvd. Apt: 1617 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No 3altimore, Maryland 21215-0036 Specify: Specify: White 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse- Johns Hopkins Hospital Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Walther Alfred E. Linton, Jr. ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sharon Heimiller - Daughter 12702 Lee Ben Road, Kingsville, MD 21087 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans\_Funeral\_Chape1

Bel \_ Air 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services - Bel - Air 3 Newport Drive, Forest Hill, Maryland 21050 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neumbhia Physician disease or condition resulting in death) /Medical Due to (or as a cons uence of) Examiner Sequentially list conditions Due to for as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 🗷 No 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐ Yes the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 → No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After t 1 Natural 2 ☐ Accident 5 Pending investigation 1 □Yes 2 □ No death. 24 hours after death Funeral Director: 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier leted cause of death (Item 23a) (Type, Prin 30 Name and address of person who comp 20 V 32. Registrar's ignatur 31. Date filed (Month, Day, Year) State 4 2009

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #30 Per DVR G894 7/04/09 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day JULY **Physician** 29, 2009 MARY VOSE GILLESPIE 1:35 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GENESIS OF LA PLATA LA PLATA CHARLES Birthplace (State or Foreign Country)
 NEW YORK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
JAN 28, 1929 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Min. 1 □ M 2 1 F Hours 218-24-0487 80 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the MacLeal Evanties In ust be retified at any Injury or other traumatic event, the MacLeal Evanties In ust be retified at any once. 10d. Inside City Limits 10c City Town or Location 10a. State 10h County 1 ☐ Yes 2 X No Director MD CHARLES HUGHESVILLE 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 7510 CARRICO MILL ROAD 20637 UNITED STATES Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY WRIGHT WILLIAM VOSE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) LINDA RADOMSKY / DAUGHTER 900 VIRGINIA AVE., BALTIMORE, MD. 21221 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland National Cemetery: 8-3-2009 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lie 22 Name and Address of Eacility Fleck Funeral Homes, Inc. 7601 Sandy Spring Road Laurel, Maryland 20707 23a. Part 1. Enter the diseas shock, or heart failure. Approximate Interval Between Onset and Death r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each Immediate Cause (Final disease or condition resulting in death) Due to (or as a Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence offi Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 X Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 □Yes 2 Was case referred to medical examiner? 26. Place of Death (Check only one) 1☐ Yes 2 No Hospital: Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient anner of Death (Natural 28h Time of 28d. Describe how injury occurred

**Physician** /Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. Division of Vital Records, P.O. Box 68760, after death.

Baltimore, Maryland 21215-0036

sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit

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Medical

:	27. Manner of De
	1 Natural
	2 ☐ Accident
	3 ☐ Suicide
	4 🗌 Homicide
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)	

Suicide Homicide 29a, Certifier

(Check only one)

and manner stated. 29b. Signatu

determined

28a. Date of Injury (Month, Day, Year) 5 Pending investigation 6 ☐ Could not be

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

20735

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

O

-009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Piscataway RD Ste 750 Atul Katyal

31. Date filed (Month, Day, Year)

AUC 0 4 2009

82. Registrar's Signature arke

State

Registrar

29c. License number

D0061652

Clinton MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 07 Physician 1:59 P M Geppi /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Best Care Assisted Living Reisterstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day. **Funeral** 1 □ M Days Hours Min 213-28-7834 Maryland 78 09-28-1930 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it. M. virca Exp. nine 1 any injury or other traumatic event, it. 10d. Inside City Limits 10a. State 10b, County 10c. City, Town or Location Director 1 ☐ Yes 2 👿 No Howard Marriottsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1938 Victory Hills Road 21104 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2 If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1∐Yes 2⊠No Specify: White Specify \$ 3 ☐ Widowed ※☑ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cosmotologist Makeup 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Xavier Leek Ethel Louise Dryden ၉ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnna King/Daughter 1938 Victory Hill Way, Marriottsville, MD 21104 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial 07-31-09 Elkridge, MD e of Funeral Service Licenses 21. Sign 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc. 7250 Washington Blvd. Elkridge MD 21075 Cle 23a. Part 1. Enfer the dis shock, p heart failu Immediate Cause (Final er the disease, or complications that 👉 sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause of each line. **Physician** Arkinson disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed<sup>a</sup> certificate 2 🗖 No 1 ☐ Yes 2 🗆 No 1 □ Yes the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: HSSISHE D 1∐ Yes 2.☐No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Man of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 □Yes 2 □ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature ar title of certifi 29c. License number 21131 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre Minkeye 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death JUN Y **Physician**  $30^{\text{pay}}$ 2009 MIRIAM **GAMEROW** 3:22 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner EMERITUS OF PIKESVILLE **PIKESVILLE** BALTIMORE Date of Birth Month Day Year) 05/05/1920 Birthplace (State or Foreign Country)
 POLAND Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. **Funeral** Months 89 125-09-4975 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 □Yes 2 No Director **BALTIMORE** BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 and 1 page. 1840 REISTERSTOWN ROAD, #208 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No WHITE Specify: Specify δ, 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **EXECUTIVE SECRETARY** SYNAGOGUE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BORIS ZINAMON MINNIE ZINAMON ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHELLIS COURT, OWINGS MILLS, MD 21117

Disposition (Name of Date 20c. Location - City or Town, State CINDY MENDELSON / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State FLORAL PARK CEMETERY | 08/02/2009 | DEANS, NJ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Restrictive Luna Discase **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 12 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> Barrett's Esochogui 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No Meurol Effections 24a. Was an certificate has birector, page 2 s autopsy Disease Altheimerts Congestive Heart failure 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Souther (Specify) ASS15+0 1 Yes 2 1 No Medical Certification: To After this nours after death.

neral Director: After this

filled in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred LIVING 1 ANatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 Karen L. D58676 Balitt M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Babitt your old court load, 14/te 301. 32. Registrar's Signature 31. Date filed (Month, Day, Year) AUG 0 4 2009 State Registrar

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Т			Decedent's Name (First, Middle, Last)					2. Date of Dea Month		3. Time of Death	_
	Physicia /Medic		ARTHURE.		G	OLDMAN		JULY 31		06:44 A <sup>M</sup>	
	Examin		4a. Facility Name (If not institution, give street and no	mber)		4b. City, Town, or	Location of Death		4c. County of	Death	
-			5071 BEATRICE WAY			COLUMBIA			HOWARD	But to the total	_
	Funeral		5. Social Security Number 6. Sex 1 M 2 □ F	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 07-13-	Year) 9	Birthplace (State or Foreign Country)	
	Director		Usual Residence of Decedent	67				0/-13-	1942	PA	-
	yland		10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits	
	e Mar mind	ctor	MD HOWARD	COLI	UMBIA					1 □Yes 2X No	
	or 28	Dire	10e. Street and Number			10f. Zip Code		1	10g. Citizen of Wha	at Country?	
	ath w	Funeral Director	5071 BEATRICE WAY			21044			USA	<del></del>	_
	er de item	-une	Armed Fo		S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Hace - Black, \	American Indian, White, etc.	
5	72 hours after death with the Maryland "natural", or items 23a or 28a-f show ploat Expruit at must be refitted at	by F	1 ☐ Never Married 2 💢 Married 1 💢 Yes If Yes, G 3 ☐ Widowed 4 ☐ Divorced Year or D	2 □ No ive Dates:		1□Yes 2XINo	Specify:		Specify:	WHITE	
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Ž		Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (	1-4or 5+)	life. I	DO NOT use retired	•	ng			
7	be filed within 72 tal Hygicne. d other than "na event, tt o Monitorial"	Con	5+		COMPU	TER SCIEN				VERNMENT	
yland	e d Hall	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	,	TMMED	
	s 1 and 2 sho ld be f Health and   enta tem 27 is marked other traumatic ev	2	SAUL  19a. Informant's Name/Relationship (Type. Print)	<u> </u>	OLDMAN	a Address (Street	REVA and Number or Run	al Bauta Numba		IMMER	
Z Z	id 2 si Ith an 27 is i		GLORIA GOLDMAN/WIFE				E WAY, CO		MD 2104		
<u>a</u>	t and the Health tem 27 other tr		20a. Method of Disposition	20b. F		sition (Name of natory or other place		Date	20c. Location - Cit		_
<u> </u>	t. Pages tment of tant: If its jury or o		1 X Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	State		_OH_CONG.	100.00	-2009	BALTIMOR	RE MD	
saitimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee	ile in the	22	2. Name and Addre	ss of Facility SOL	LEVINS	ON & BROS	S. INC	
מ	B m m G		Alichak Non	never	89	900 REIST	ERSTOWN R	OAD, PI	KESVILLE	, MD 21208	
			23a. Part . Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death	h. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	elanomi	A					Onset and Death	
	/Medical Examiner		resulting in death)  Due to	(or as a consequ	uence of):					7	
		-	Sequentially list conditions, if any leading to immediate	(or as a consequ	uence of):						_
	uted 1 Insit	Examiner	cause. Enter Underlying	(0. 0.0 0.004)							
ĵ,	executed in and ial-transit		that illitiated events	(or as a consequ	uence of):						_
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-	ing ph		IF FEMALE:								
ROX	ath ce	ian/	23b. Was decedent pregnant in the past 12 months?	itcome of pregna birth 2☐Feta	Ideath 3	Ectopic pregnanc	у		23d. Date of Month	,	
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J.	w requires that the death certific been signed by the attending I should be detached for use as		Part II. Other significant conditions contributing to o	leath but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribu	ute to the cause of death?	
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VITA	ian; irtifica stor, p	BeC	25. Was case referred to medical				26. Place of Deat		<del>/                                    </del>	11e3 2 11e0	_
O _	hysic his ce I direc	으	examiner? 1 Yes 2 No Hospital:	Inpatient 2	ER/Outpatier	nt 3 □ DOA Oth	er: 4 🗆 Nursing Ho	me 5 Resid	ence 6 Dother	(Specify)	
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<u>s</u>	ttend death tor: /	icati	2 Accident investigation 3 Suicide 6 Could not be 38e Place	o of Injury At he	mo form etr		Yes 2 □No	20f Location (C	Stroot and Niverbau	or Pural Pouta Number	_
UNISION	or At after of Direction by	Certification:	4 Homicide determined build	ing, etc. (Specif	fy)	eet, factory, office		City or Tow		or Rural Route Number,	
D	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 of the funeral director, page 2 to the funeral director, page 2 to the funeral director.		29a. Certifier (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Ch	basis of examina							_
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			30. Name and address of person who compared cau	se of death (Iten	n 23a) (Type,	Print)	-J v 1		, , , , ,		_
			William Sharforn	1075	3 Fm]	15 Rd	#415,6	Meil	10, Md.	21093	
	Sta Registr		31. Date filed (Month, Day, Year)  AUG 0 4 2009	Registrar's Signa	ature fav	del .	·			21093	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August 03,2009 ear **Physician** 4:50 P. M Georgie Hurt Hampshire /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Daltimore County Towson Gilchrist Hospice Center If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Sept. 22, 1919 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Cedar Bluff, VA. Min. Months 1 □ M 2 🖺 F 89 242-20-8822 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, It a Modical Examiner must be notified at 1 ☐ Yes 2 No Timonium Director Maryland Baltimore County 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21093 15561 Roundwood Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 No Black, White, etc. within 72 hours after 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 🖺 No Specify: 2 White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within the and Mental Hygiene.
7 Is marked other than "I Elementary/Secondary (0-12) College (1-4or 5+) Own Hone Home Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eunice Margaret Watkins Reuel Jay Hurt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other trau 21204 9 Barrow Court Towson, Maryland Madeleine H. Tolman (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place)
EVans Funeral Chapel 20c. Location - City or Town, State 20a. Method of Disposition Date August 2009 05, 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Peaceful Alternatives Funeral&Cremation 2325 York Road Timonium, Maryland 2 21. Signature of Funeral Service License 23a. Part f. Ente/Ine diser j, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock for heart fail fre. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COWS **Physician** disease or condition resulting in death) /Medical Due as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed signed by the attending physician and a be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 3 Probably 4 ☐ Unknown Dilmonar antent 1 ☐ Yes 2 ☐ No been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.
To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. autopsy performed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Souther (Specify) NOST LL 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury/occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

DHMH 17 Rev 1/2001

State

(Check only one)

31. Date filed (Month

29b. Signature and title of certifier

HARON

Year.

(5701

29c. License number

Chorus

29d. Date signed (Month, Day, Year)

and manner stated.

HANES M

32. Registrar's

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 1213 2009 7 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE
If Under 1 Year | If Under 24 Hrs. | Hours | Min. BAYVIEW Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month. Day. 5. Social Security Number Year) **Funeral** Days Hours Months **™** M 2□ F 215-52-0037 12/27/1947 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State 28a-f show Expriner nust be notified at 1 ☐ Yes 2 🔀 No Director Baltimore Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number ö 76 Berkshire Road 21221 U.S.A. items 23a Funeral permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23: any injury or other traumatic event, It w Modical Examinations 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Yes 2 f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White þ 3 ☐ Widowed 4 🎇 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Bethlemhem Steel Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frances Slawski Stanley Joseph Hartman, Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3016 Lavender Avenue, Parkville, MD 21234 Arlene Gring/ Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 08/05/09 Parkville, 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 21. Signature of Funeral Service License 23a. Parth. Enter tile disease, or complications that caused the death. shock, or hearty allure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** Thour resulting in death) hypoxemia ase or condition /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, flany leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last massive Examine the Hospital or Attending Physician: The law requires that the death certificate be executed masmall attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 2 No 3 Probably 4 Unknown Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □ Yes 2 No 1 🗌 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only o e) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 1 Inpatient Certification: To After this within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a
To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar 30. Hame and address of person who completed cause of death (Item 23a) (Type, Print)

SPEEL

0 4 2009

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 21 per ffi, g894,08/04/09dnb Certificate of Death Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Hampton Royce Ray 2009 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Min. 401-58-9828 1 X M 2 □ F 66 02/03/1943 Kentucky Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County Timonium MD Baltimore

**Physician** /Medical Examiner Baltimore 9. Birthplace (State or Foreign **Funeral** Director 10d. Inside City Limits show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov ary or other traumatic event, the Medical Examinar must be in affect at 1 □Yes 2X No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21093 USA 12202 Burncourt Rd, #102 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 □Yes 2**X** No Specify: Specify. ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Baltimore County College (1-4or 5+) Custodian Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Olga Castle Engle She1by R. Hampton ဂ 19a. Informant's Name/Relationship (Type. Print)

Carol Hampton - Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12202 Burncourt Road, #102, Timonium, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page:
Department o
Important: If
any injury or
once. Hilltop Service Corp. 07/31/2009 Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee Paul Hagan per DVR 1050 York Road, Towson, MD 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PERIPHERAL VASCULAR DISEASE YEARS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending pl 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 gig a CLOSTRIDIUM DIFFICILE COLITIS 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed has

CHRONIC RENAL FAILURE

24a. Was an autopsy performe 1 □Yes 2 No

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death? 2 No

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide

5 Pending investigation 6 ☐ Could not be

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier CM, selle. Sc.

Hospital:

D36663

29d. Date signed (Month, Day, Year) 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OSLER DRIVE TOWSON, MARYLAND 21204 R. M. D. STUART WILLES 32. Registrar's Signature

State Registrar

director.

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Certification: To

Medical

		for State	State of Maryland	d / Dep		lealth and N	lental Hyg	jiene	21.795
_	-	Registrar  1. Decedent's Name (First, Middle, Las.	t)		Timeate or	Death	2. Date of Dear	Reg. No. Z U U J	3. Time of Death
Physici /Medic		Gloria Lory	Heins				Month	3, Day 2009 Year	7:45 A <sup>M</sup>
Examir	ner	4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death		4c. County of Death	_
		Heritage Nursing	Home		Annapoli			Anne Arund	
Funeral Director		217 22 0213	7. Age (In yrs. I	ast birthday, Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 01-26-1	9. Birth Cou	place (State or Foreign intry) York
pu »		Usual Residence of Decedent  10a. State 10b. County	100 Cib	Town on L					10d. Inside City Limits
show	<u> </u>			, Town or L					1 ☐ Yes 2 1 No
Ba-f	Director	70000	ne's			evensvill			
iff the	Ë	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What Cou	intry?
ath w	ra	119 Twin Cove Roa				1666			States
tems	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
S affe	by F	1 Never Married 2 Married	1 ∐Yes 2XXNo If Yes, Give		1 ☐ Yes 2 🕱 No	Specify:		Specify:	[7]
iled within 72 hours after death with the Maryland Hygiene. Whysiene. Wher than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at		3 <b>XX</b> Widowed 4 □ Divorced	Year or Dates:	10.0					White
"nat	Completed	15. Decedent's Edi (Specify only highest grad	ucation de completed)	(Give	edent's Usual Occup kind of work done	durina most of work	ing	16b. Kind of Business/I	ndustry
vithir	盲	Elementary/Secondary (0-12)	Coffege (1-4or 5+)	iiie.	Bank Te	*		Banking	
Hed v		17. Father's Name (First, Middle, Last)	<u>Z</u>	_	Dank Te		o (First Middle	Maiden Surname)	<u> </u>
be f ed or	Be	Ernest Lory				Helen B		waiden Surrame)	
2 should be and Mental is marked or raumatic even	은			1					
12 st h an 7 is r traur		19a. Informant's Name/Relationship (7)			_			r, City or Town, State, Z	
l and Health	0	Donna L. Moran -		<del></del>				e, Maryland	
Pages nent of hunt: If Ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	emetery, cře	osition (Name of matory or other place	ce)	Date	20c. Location - City or T	
Pa tmen tant: jury	ì	4 ☐ Donation 5 ☐ Other (Specify	Atl		Cremator	- '		Glen Burnie	
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturany injury or other traumatic event, the Medical once.		21. Signature of Funeral Service Licens	See O					ufman Funer	
		May 13. 1.	sur havin					., Elkridge	, MD 21075
		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death one cause on each line.	. Do not er	nter the mode of dyin	ng, such as cardiac	or respiratory arr	rest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Card	cae	Myth	ouia.			Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):	- 1				
Examiner	L	Sequentially list conditions.	b						
ait a	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury	Due to (or as a consequ	uence of):					
and -tran	Kan	that initiated events resulting in death) Last	c						
icate be executed physician and the burial-transit			Due to (or as a consequ	ience oi):					
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The law requires that the death certificate are has been signed by the attending physoage 2 should be detached for use as the last the last are as the last are as the last are as the last are as the last are as the last are as the last are as the last are as the last are are as the last are are as the last are are are are are are are are are are	hysician/Medi	IF FEMALE:	00- 1						
ath c iffend or us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal	death 3	☐ Ectopic pregnanc	;y		23d. Date of deli Month	very Day Year
at the de	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of d 9 ☐ Unknown	eath 5	Other (specify) _			World	Day Toal
that the	Ph			ultin n la Nh n		and to Do All	00- Bida-		N
res ti	þ	Part II. Other significant conditions co	announg to death but not rest	ating in the t	underlying cause giv	en in Part I,		bacco use contribute to	
w requir	ted						1 L Y	es 2 □ No 3 □ Pro	obably 4 Unknown
law las b	Completed						24a. Was a		topsy findings available completion of cause of
	ρ						perfor	med? death?	2 □No
Attending Physician: The death. ector: After this certificate by the funeral director, pag	Be (	25. Was case referred to medical examiner?				26. Place of Deat			
ils dir	10	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	ent 3 DOA Oth	er: Nursing H	ome 5 Resid	ence 6 Other (Spec	cify)
ng Ph fter th		27. Manner of Death  Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	of 28c. Inju			ow injury occurred	
ath.	atic	2 ☐ Accident investigation		,,		Yes 2 □ No			
er de recto	iji.	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, st	treet, factory, office		28f. Location (S City or Tow	Street and Number or Ru	ral Route Number,
tal or s after al Dir	Certification:	4 Littornioide	building, etc. (opean)	"			City of Tow	ii, Siale)	
ospit hour unera ly fille		29a. Certifier Certifying Phy	ysician: To the best of my kno	wledge, dea	th occurred at the ti	me, date and place	, and due to the	cause(s) and manner as	stated.
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral	edical	(Check only 2 Medical Exam	iner: On the basis of examina and manner stated.	uon and/or i	rivestigation, in my	opinion, death occu	rred at the time, o	uate and place, and due	to the cause(s)
With Volume	Ž	29b. Signature and title occertifier			29c. Licens	se number	2	29d. Date signed (Month	n, Day, Year)
					De	37028		8-3-09	Ì
7		30. Name and address of person who c	completed cause of death (Item	23a) (Type	, Print)	4 4			
		1 / (	a.M. P. Cel	00 R	idsely,	Ave- HZ	is (An	inapolis r	ND 21401
Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	1				

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 4:23 P Aug. 2009 Edith Josephine Hoeflich 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** Gilchrist Center Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 17 1920 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 □ M 2 □ Months Days Hours $\mathbf{V}\mathbf{A}$ 89 220-05-3290 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 □Yes 2 □ No **Timonium** MD **Baltimore** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21093 USA #8 Bally Cruy Ct. Unit 201 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Work Canton Railroad n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alberta G. Schmidt George J. Hoeflich 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John H. Schmidt/Cousin/POA 7209 Meadow Wood Way, Clarksville, MD 21029 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition **X**Burial 2 ☐ Cremation 4 Donation Parkwood Cemetery 8/6/09 Parkville, MD 5 Other (Specify) 22. Name and Address of Facility Lemmon, Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 Michael J. Flagi caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause of Immediate Cause (Final multi-lobar neumonia week s disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any county of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 □ No 1 ☐ Yes 1 □Yes 2 No

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a State

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

Completed by

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Certification: To

Medical

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, I'm Markeal Examinating must burnetiffed in

12 should be filed within 72 th and Mental Hygiene. 7 is marked other than "na

Department of Health

Pages 1

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-trar signed by the a

cate has l page 2 s certificate director, After th funeral

68760 ₹ To the Hospital or Attending Division death, within 24 hours after death

To the Funeral Director:
completely filled in by the

Box ( o σ. Records, Vital

State Registrar 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) 1∐Yes 2XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work?

5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 20 Medical Examiner: On the basis of examination and/or investigation in the second death. 29a. Certifier

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Day, Year) 0 4 2009

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print) Codar

32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 200<sup>Year</sup> 2, Marie Antoinette Harrison August 6:20 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 106 Indian Plantation Drive Stevensville Queen Annes If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 9, 9. Birthplace (State or Foreign Country) Mary Land 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Min. Days Hours 1 □ M 2 🗓 F 216-74-9709 50 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Stevensville Maryland Queen Annes 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 106 Plantation Drive 21666 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever In U.S. Armed Forces? 1 ☐Yes 2 ☒No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2X No White If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marcus Sansone Patricia Parrish 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas R. Harrison, Husband 106 Plantation Drive Stevensville, Maryland 21666 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Metro Crematory Inc.: 08/03/09 Baltimore, Maryland 22. Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryl 21. Signature of Funeral Service Lice (Se Thomas Gregor Maryland 21228 oma 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pancreatic Cancer 3 Mos disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Exter tradelly in Cause (Disease or injury Due to (or as a consequence of). that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nerform 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner

Department of H Important: If ite any Injury or of

**Physician** 

/Medical

Examiner

Director

Funeral

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**Funeral** 

Director

item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Exambre in ust be multibled at

Pages 1 and 2 should be filed within 72 hours after of the sound of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ites

altimore, Maryland 21215-0036

death

Hospital or Attending Physician; The law requires that the death certificate be executed as the burial-tran attending p within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached?

P.O. Box 68760

Division of Vital Records,

Examine Physician/Medical

Completed by Be Certification: To Medical

Registrar

David C. Halverson 31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

2 Accident

3 🗌 Suicide

29a. Certifier

4 Homicide

(Check only one)

30. Name and address of person who completed cause of death (Item 25a) (Type, Print)

6 □ Could not be

2 Medical Examiner: On

8821 MD 32. Registrar's Signature

hanner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

TEAL DR Suite 302

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: Or the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

3 0

MD

Easton,

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Lula House July 2:17-AM 27 2009 /Medical 4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL OF BALTIMORE 4b. City. Town, or Location of Death 4c. County of Death **Examiner** NA BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ Months Days Hours 220-12-9025 86 NC Director Usual Residence of Decedent 10b. County 10c, City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a fredical Eyaminar must be notified at 1 XYes 2 ☐ No Director NA MD Baltimore 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21223 USA 1700 Edmondson Avenue Apt.#224 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates; Black, White, etc. African 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2X No Specify: Specify: American þ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5th Grade ÑΑ Home Maker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Butler Johnson Marie Fred ျှ and N 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1700 Edmondson Avenue Apt.#224 Baltimore Mary Alice Carter-Daughter injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 X Xurial 2 ☐ Cremation 3 ☐ Removal from State King Mem. Pk. 08-01-09 Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PULMONARY Physician DAY disease or condition resulting in death) /Medical Due to (or as a consequence of): DAY Examiner CONGESTIVE HEART FAILURE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be execut Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 CORONARY ARTERY DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 ■No HYPERLIPIDEMIA 2 No 1 ☐ Yes 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ☑ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Paul agrawal, MD RES - 000

DHMH 17 Rev 1/2001

State Registrar

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SINAI HOSPITAL OF BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TAY PAUL AGRAWAL, MD

31. Date filed (Month, Day, Year)

32. Registrar's Signature

# Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible.

			for State Registrar	State	of Maryla	and / Depa	artment of			/lental Hy	giene Reg. No.2	009	24799
M			Decedent's Name (First, Middle)	le, Last)			imouto or	Boant		2. Date of De		000	3. Time of Death
	Physici		John Lattimore	Henderso	าก					July	24	2009	10:07 A M
	/Medio Examin		4a. Facility Name (If not institutio				4b. City, Town,	or Location	of Death	0 02		ounty of Death	_1
	LAGIIIII	ICI	6431 Whitwell		,		Fort W					nce Ge	
Т	Funeral		5. Social Security Number	6. Sex	7. Age (ln )	rs. last birthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Bi	rth	9. Birth	pplace (State or Foreign
	Director		303-34-3314	1⊠M 2□F		74 Yrs.	Months Days	Hours	Min.	July 28	av Yearl	Cor	intry) tucky
	D		Usual Residence of Decedent										
	how	_	10a. State 10b. County			City, Town or Lo							10d. Inside City Limits
	a-f s	cto	MD Princ	e Georges	F	ort Wash	ington						1 □Yes 2 🖾 No
	th th	Director	10e. Street and Number	_			10f. Zip Code	-			10g. Citize	n of What Cou	intry?
	23a	<u>a</u>	6431 Whitwell	Court			2074	44		4	USA		
	ems	Funeral	11. Marital Status	12. Was Dec	cedent Ever in	n U.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Or	rigin? (Sp	ecify Yes or No	o- 14.	Race - Amer	
20	afte or it	표	1 Never Married 2 Mar	ried 1 ⊠Yes	2 🗆 No		1 ∐Yes 2 ⊠ No			rticari, etc.,	1	Black, White <sub>bec<i>ify:</i> bla</sub>	
215-0036	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or items 23a or 28a-f show ant, the Medical Exa uhar must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or	Dates: unk		LITO LLIN	, openy.			5	becny: 5 = G	
7	72 h "natu	Completed	15. Deceder (Specify only highe	nt's Education est grade completed	)	16a. Dece	dent's Usual Occi kind of work don DO NOT use retir	upation e during mos	st of work	ing	16b. Kind	of Business/I	ndustry
Z	vithin ne. han	E D	Elementary/Secondary (0-12)		(1-4or 5+)	· ·					IIan	a Cani	ety of US
N	e filed v al Hygie other i	ပိ	12	( 0		mar.	Lroom cl	т	. 1 . 11	/FiA 14:-4-0-			ety of 05
/land	buld be fi Mental I arked of atic ever	Be	17. Father's Name (First, Middle, Bill Henderso	•						e (First, Middle nilton	, Maiden Su	irname)	
Ε.	d 2 should be filed within 72 ho th and Mental Hygiene. 7 is marked other than "natu traumatic event, it e Medical	မ									_		
<u>a</u>	d 2 sl th an <b>7 is r</b> traur		19a. Informant's Name/Relations			940 <b>1</b>	ng Address <i>(Stree</i> H <b>urstb</b> ou	et and Numb irne C	er or Run 1055:	al Route Numb ing Dri	er, City or T .ve; A <sub>1</sub>	own, State, Z pt 148	ip Code)
a,	1 an Heal em 2 ther		Derrick Hende 20a. Method of Disposition	rson/son	201	Louis	ville, K	Centuc		0299 Date	200 1000	tion City ou 7	Tarrier Charles
בַ	0 = 5		1 ☐ Burial 2 ☐ Cremation	3 Removal from	⊱State 201	<ul> <li>Place of Dispo cemetery, crer</li> </ul>	natory or other pl	ace)	ı	Jale	zuc. Loca	tion - City or T	own, State
Baltimor	it. Pag rtment rtant: i		4 □ Donation 5 □ Other (S	3 / /	ate			i					
g	permit. Pag Department Important: l any injury c		21. Signature of Funeral Service	Wade, D	irecto:	r  St	Name and Add ate Anal	omy B	oard		Balt:	imore S	Street
			23a. Part 1 Enter the dis ase, or	completions that	caused the d		ltimore				vero ot		Approximate
			shock or heart failure. List Immediate Cause (Final	only one cause on	each line.	0	-10					4	Approximate Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	a. OK	Inre		alre C	zereli	-cW	Stole	110	case	Un Knowed
1	Examiner		<b>3 2</b> ,	Due to	(or as a cons	-	)						4.
		r e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Duo to	(or as a cons	1 Eas	ZON						Un Known
	nsit	Ē	cause. Enter Underlying Cause (Disease or injury that initiated events		Of as a cons		8 True	li.	1	1 Ms	1		
	al-tra	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a cons	sequence of):	18/ 1000	-/	un-	3 1000	cere	- 4	hold mount
04/0	icate be executed physician and the burial-transit												
00	ficate phy s the	edical		d									
Š	certi nding Ise a	Physician/Me	IF FEMALE:	23c. If yes, or	tcome of pre	gnancy					000	d Data of data	
0	eath atter for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 F	etal death 3	Ectopic pregnar Other (specify)	псу			230	<li>d. Date of deli Month</li>	very Day Year
j .	the d y the ched	iysi	1 □Yes 2 □ No 9 □ Unknown	9 □ Unk		or dodin 3 L	d Other (specify)			_			
Τ.	that ned b deta		Part II. Other significant condition	ons contributing to	death but not	resulting in the ur	nderlying cause g	iven in Part I	l,	23e. Did :	tobacco use	contribute to	the cause of death?
cords,	ding Physician: The law requires that the death certifinh.  After this certificate has been signed by the attending funeral director, page 2 should be detached for use as	d by								1 🗆	Yes 2 □ I	No 3∏ Pro	bably 4 hiknown
5	w req	Completed								04-11/-			* * * * * * * * * * * * * * * * * * * *
ב ב	nelav ehas ge-2	E D								24a. Was		prior to c death?	opsy findings available ompletion of cause of
III	n: Ti ficate or, pa		05 146							1 □ Yes			2 □ No
>	sicia cert irecto	Be	25. Was case referred to medical examiner?	Hospital:			100	ib a si		h (Check only o			
5	Phy ir this	5. T:	1 Yes 2 2 No 27. Mann f Death	28a. Date		ER/Outpatier 28b. Time of	1 3 DOA	4 🗆 NI		me 5 Resi			ify)
	ding h. fune	햩	1 Matural 5 ☐ Pendin	g (Moi	nth, Day, Year	njury	Wo	ork? ∐Yes 2 🗀		28d. Describe	now injury o	ccurred	
2	dear dear ctor: y the	fica	3 ☐ Suicide 6 ☐ Could	and he	e of Injury - A	t home farm str				28f Location /	Stroot and h	Jumbas as Du	ral Route Number,
<u> </u>	after after Dire	ertification:	4 ☐ Homicide determ	build	ling, etc. (Spe	t home, farm, streecify)	oct, lactory, office			City or To	wn, State)	vulliber of hu	al noute Number,
	To the Hospital or Attending Physician: The law requires that the death certiful 24 hours after decest.  Within 24 hours after decest.  Within 24 hours all prector: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	0	29a. Certifier 1 Certifyir	ng Physician: To th	e best of my l	knowledge, deatl	n occurred at the	time, date a	nd place.	and due to the	cause(s) ar	nd manner as	stated.
	in 24 in 24 in Eu	edical	(Check only 2 Medical one)	Examiner: On the	basis of exam nner stated.	nination and/or in	vestigation, in my	opinion, dea	ath occur	red at the time,	date and pl	ace, and due	to the cause(s)
ı	0 7 kit	Σ	29b. Signature and title of certifie	on de				ise number				signed (Month	, Day, Year)
			1 100/1	vueces	2.		50	545	54		Jul	7228	12009
•			30. Name and address of person	who completed cau	se of death (I	tem 23a) (Type,	Frint) 235	- /	0	1= 1	100		
	Sta	to	31. Date filed (Month, Day, Year)	32.1	Registrar's Sig	⊒ ≯uu	K USJ	ce	12	iew M	<i>Y</i> -	0 /	3 7
	Registra		AUG 04	2009	ma	A. Soc	Kel						

09-05497 Robert E. Hahn Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

obert E. Hahn		State of Maryland / Department of Health a	and Mental Hy	giene Reg.	No. 200	19 2480
Physician	/ 1	egistrar . Decedent's Name (First, Middle,Last)		2. Date of Death	av Year	3. Time of Death 2203 hrs
ledical Examine		Robert E. Hahn  a. Facility Name (if not institution, give street and number)  4b. City, Town	n, or Location of Death	July 13, 200	9 4c. County of Death	
	-	50 Summit Avenue Hagersto			Washington	
Funeral Director		Social Security Numberunk 6. Sex 7. Age (In yrs. last birthday) If Under 1 Months	Days Hours Min.	8. Date of Birth(		hplace (State or munk untry)
any	_	Usual Residence of Decedent  0a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	1	MD Washington Hagerstown				1 Yes 2 🔀 No
Aaryłand 28a-f show 1 at once.	ector	0e. Street and Number 10f. Zip Co.		10g	. Citizen of What Cour	ntry?
th the Maryland 23a or 28a-f sho notified at once.	5	50 Summit Avenue 217			USA	District Co. District
th with tems 2 st be n	ωl	1 Never Married 2 Married Armed Forces? UNK If Yes, specify C	f Hispanic Ongin? (Spuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	White, etc.	ican Indian, Black,
fter dez		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X	No specify:		Specify: Whi	te
ours al		15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occ during most of working	cupation (Give kind of w	vork done 1 red) <b>unk</b>	6b. Kind of Business/	Industryunk
36 in 72 h han "r	mpleted	Elementary/Secondary (0-12) College (1-4 or 5+)  unk unk				
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	탕	17. Father's Name (First, Middle, Last) unk	18.Mother's Name	(First, Middle, Ma	iden Surname) un	k
215 lbe file ental H arked o	8	19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (		Secret Dente Memb	es Citues Town State	Zin Codo)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	-1	19a. Informant's Name/Relationship (Type, Print )  O.C.M.E. 111 Penn St				
e, M I and 2 Health item 2	- 14-	20a. Method of Disposition 20b. Place of Disposition (Name			20c. Location - City or	
Mor Pages   ent of   mt: If		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X other Specify: in State				
Baltimore, permit. Pages I ar Department of He Important: If the injury or other tr	t	21. Sunature of Funeral Survice Lichosee. 22. Name and Ad State A	dress of Facility natomy Boar	rd 655 W	Baltimor	e Street
	1	Raltimo	re, Marylai lying, such as cardiac c	nd 21201 or respiratory arres	t, shock, or heart	Approximate Interval
Physician 'Medical		failure. List only one cause on each line.  Immediate ouse (Final disease a Atherosclerotic Cardiovascular Disease				Between Onset and Death
aminer		or condition resulting in death)  Due to (or as a consequence of):				
	ا <u>د</u>	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):				
	Examiner	cause. Erner Underlying Cause (Disease or injury that initiated  Due to (or as a consequence of):				-
uted Id ransit	۵Ì	events resulting in death) Last Due to (or as a consequence or).				
50, te be executed tysician and burial - transit	ledical	UNPENDED AMENDED				
Box 68760, e death certificate be the attending physic ad for use as the burned.		IF FEMALE: 23b. Was decedent pregnant in the 2 Fetal death	3 Ectopic pregn	ancy	23d. Date of delive Month	ry Day Year
30x 6876 death certificate e attending phy I for use as the I	icial lei	past 12 months?  4 Pregnant at time of death 5 Other (Specifi			4	
. Bo	Physician/IV	1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contributions.	ause given in Part I.	23e. Did tob	pacco use contribute to	o the cause of death?
, P.O. B ires that the d signed by the		Emphysema		1 ✔ Yes	2 No 3 Pro	obably 4 Unknown
aw require	Completed by	Gastro-intestinal Hemorrhage		24a. Was a		autopsy findings available completion of cause of
eco he law ate has age 2 s	E I			perform 1 ✔ Yes 2	med? death?	processors.
tal Reco	Be	evaminer?	Place of Death (Check			
1 of Vital Records, ling Physician: The law requir After this certificate has been s funeral director, page 2 should I	은	1 Yes 2 No Inpatient 2 ER/Outpatient 3 DO	A Nursi c. Injury at Work?		Residence 6 Oth Own	er; Scene
ion of tending Pl eath. tor: After the funera	Eion:	1 Natural 5 Pending (Month, Day,Year)	Yes 2 No			
Division spital or Attendir hours after death. meral Director: A	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, could not be determined (Specify)	office building, etc.	28f. Location (S or Town, St		Rural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the ti (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my one one of mannar stated.	me, date and place, an pinion, death occurred	d due to the cause at the time, date a	e(s) and manner as st and place, and due to	ated. the cause(s)
F 3 F 8	Me	29b. Signature and title of certifier 29c.	License number	OCME	29d. Date signed (A	fonth, Day, Year)
		C mil	O.C.M.E.		July 14, 2009	
		30. Name and address of person who completed cause of death (Item 23a)  David Fowler M.D. Chief Medical Examiner 111 Penn Street, Bal	itimore, MD 2120	1		
St	ate	31. Date filed (Month, Day, Year)  32. Régistrar's Signature				
Regist	rar	ALIG 0 4 2009 Bereva B. Sales				

		State of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department / Department / Department / Department / Department / Department	artment of Health and Martificate of Death	lental Hygie	_/HH4	24801
		1. Decedent's Name (First, Middle, Last)		2. Date of Death	D V	3. Time of Death
Physici		Frances Mae Hobbs		Month August	1 2009	6:15 a. <sup>™</sup>
/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
Z		Franklin Woods Nursing Home	Rosedale		Baltimor	e
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign intry)
Director		212-32-3582 1 N 2 F 92 Yrs.	Months Days Hours Will.	Jan. 15.		ryland
D .		Usual Residence of Decedent				
rylar	_	10a. State 10b. County 10c. City, Town or Lo				10d. Inside City Limits
Ma a-fs	cto	Maryland Baltimore Sparrows	Point			1 □Yes 2√∑No
th the	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	intry?
th wit	al	7328 Hughes Avenue	21219	Ur	nited Stat	es
deal	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp. f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Bican, etc.)	14. Race - Amer Black, White	
after or ite	F	1 Never Married 2 Married 1 TYes 27 No	1 □Yes 2 □XNo Specify:	, , , , , , , , , , , , , , , , , , , ,		ite
ral",	d by	3XXWidowed 4 □ Divorced If Yes, Give Year or Dates:	A speak		Specify. WI	
72 h	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of workl DO NOT use retired)	ing 16t	b. Kind of Business/I	ndustry
thin le.	면	Elementary/Secondary (0-12) College (1-4or 5+)	OO NOT use retired)			
ygier ygier t, th	S		eria Manager			Public Sch
tal H	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai	den Surname)	
Men arke	ဥ	Vernan Harp	Maude Ba	asseman		
sho and is mi		19a. Informant's Name/Relationship (Type. Print) 19b. Mallin	ng Address (Street and Number or Run	al Route Number, C	ity or Town, State, Z	ip Code)
and and a salth					nt, Md. 21	
of He		20a. Method of Disposition 20b. Place of Dispo	sition (Name of Inatory or other place)	Date 200	c. Location - City or T	own, State
Page rent nt: If		TABUITAL 2 LICIETTATION 3 LI HEITOVALTIONI STATE		7, 2009	Baltimore	e, Md.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exeminal must be notified at once.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility			
Der Der Der Der Der Der Der Der Der Der		D	uda-Ruck Funeral I 922 Wise Avenue I	Home of Du	undalk, Ir	1C.
	-	23a. Part 1. Enter the disease of complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	er the mode of dying, such es cardiac	or respiratory arrest	, aryranu	Approximate
		shock, or heart failure List only one cause on each line.  Immediate Cause (Final				Interval Between Onset and Death
Physician /Medical		disease or condition a. Cvd >T+4	e Dementi	A		
Examiner		Due to (or as a consequence of):	•			
	j.	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):				
ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury				
cate be execu physician and the burial-trar	xar	that initiated events c.  resulting in death) Last Due to (or as a consequence of):				
cate be executed physician and the burial-transit	dical E					
icate phys	dic	d				
eath certific ettending p for use as	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deli	von
eath of	ian	in the past 12 months?	Ectopic pregnancy Other (specify)		Month	Day Year
at the de by the tached	ysic	1 Yes 2 No 9 Unknown	JOther (specify)			
hat ti		Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ires that signed be det	þ			1 🗆 Vas	2  No 3  Pr	obably 4 Dhknown
w requir been s should	Completed					
law nast	d d			24a. Was an autopsy	prior to o	topsy findings available completion of cause of
The I	Son			performed 1 ☐ Yes 2	d? death? Olo 1 ∐ Yes	2 🗆 No
nysiclan: The lav nis certificate has director, page 2	Be (	25. Was case referred to medical examiner?	26. Place of Deat	h (Check only one)		
Physic this or al dire		1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpatien	nt 3 DOA Other: 4 Nursing Ho	ome 5 ☐ Residenc	e 6 □Other (Spec	cify)
I or Attending Physician: The law requires the after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be done.	ü	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 28b. Time of (Month, Day, Year) 1 Injury	f 28c. Injury at Work?	28d. Describe how	injury occurred	
endii ath. vr. A	atic	2 Accident investigation	M 1 ☐Yes 2 ☐No			
er de	tific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, structure building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, S	et and Number or Ru State)	ral Route Number,
Hospital or Attending Physiclan: The law requires that the death certific 14 hours after death. Funeral Director: After this certificate has been signed by the ettending p tely filled in by the funeral director, page 2 should be detached for use as t	Certification: To				,	
bount hount hour hour hy fills	a	29a. Certifier Certifying Physician: To the best of my knowledge, deal	h occurred at the time, date and place,	and due to the cau	se(s) and manner as	stated.
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	ivesugation, in my opinion, death occul	red at the time, date	and place, and due	to the cause(s)
To th within	ž	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month	n, Day, Year)
		) Ou _ ms	053462		8/3/09	
_			Print)			
5		Jude Muneses MA 7845	Print)  DAKWOOD Rd.	Colem Po	ornie m	D 21061
Sta	te	31. Date filed (Month, Day, Year)  32. Registrar's Signature	Annual Past	~(W) .V	- 1 1116 411	7,001
Regist		31. Date filed (Month, Day, Year)  32. Registrar's Signature				
		AUG V A EUVV /				

Registrar DHMH 17 Rev 1/2001

# **Physician** /Medical Examiner **Funeral** Director death with the Maryland Director Funeral 72 hours after Completed by d 2 should be filed within 7: th and Mental Hygiene. **7 Is marked other than "n** Maryland Be ၉

**Physician** /Medical Examiner

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Clin

Baltimore,

DIVISION OF VITAL RECORDS, P.O. BOX 68/60	o the Hospital or Attending Physician: The law requires that the death certificate be executed	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year 59 PM Helen M. Heim 3 29 2009 7 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death FRANKLIN Square Hospital Center Rosedale BalTimore 8. Date of Birth (Month, Day, Ye March 27, 1 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours 1 ☐ M 2 ☐ F 73 212-34-9648 Maryland Usual Residence of Deceden 10c. City, Town or Location 10a, State 10b. County 10d. inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at N/A Baltimore Maryland 1 X Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21206 USA 5915 Cedonia Avenue 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. White Specify: 3 ₩ Widowed 4 Divorced Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 9 18. Mother's Name (First, Middle, Maiden Surname) Catherine Kahler 17. Father's Name (First, Middle, Last)
Robert List Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 tment of Health 8 John E. Heim III/ Son 6263 White Birch Road Sykesville, Maryland 21784 27 permit. Pages 1 and Department of Healt important: If Item 2' any injury or other: once, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dulaney Valley Mem. Gardens 8/3/09 Timonium Maryland Leonard J. Ruck, inc. 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cancer non small cell Type Lung disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of): To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the bunal Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 Unknown Lymphocytic Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No pulmonary Fibrosis 24a. Was an was ... autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified JULY 29, 2009 D63054 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 FRANKIN SOURCE PRIVE, BALTMORE, MD MINIO CINA, MO 9000 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/200

State

Registrar

AUG 0 4 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 28 **Physician** Lois I. Heusler dly /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ACTIMORE WASHINGTOW MEDICAL Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 X F 216-20-0740 25,1926 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 1 ∐ Yes 2x∑xNo other traumatic event, the Mudical Examinar must be multifued Director Maryland Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö 23a 21060 United States 7466 Furnace Branch Road Apt. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status 1 ☐ Yes 2X☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 📉 No Specify: ģ 3 Widowed 4 □ Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry 12 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r filed withir I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Beverage Industry 11 Years Auditor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anne Rice George Crawford ပ္ and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21122 1205 Hillside Road Pasadena, Maryland June Martin (Daughter) of Health 27 Important; If item any injury or othe 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/1/2009 Parkwood Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) al Service Licens 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that cause dithe death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OBCTRUCTURE **Physician** resulting in death) /Medical De to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760. physiciar The law requires that the death certificate be Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant atter 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a Ö 1 ☐ Yes 2 ☐ No 9 Unknown σ, 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 nknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? has certificate 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 27. Manny of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

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Name and address of person who completed ca

31. Date filed (Month, Day,

se of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** iatherine 5:30 AM mah 31 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** The Johns Hopkins Hospital Baltimore City Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. . Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 - M 2X Director Usual Residence of Decedent with the Maryland or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits res 2 ☐ No Funeral Director MD Himore 10e. Street and Number 10g. Citizen of What Country? ö ms 23a or must be r Pages 1 and 2 should be filed within 72 hours after death Race - American Indian, Black, White, etc. Marital Status Armed Forces?
1 ☐ Yes 2 No
If Yes, Give
Year or Dates: Examiner 1 Never Married Married Baltimore, Maryland 21215-0036 ò 1 Yes No. Specify Completed by 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education ind of work done during most of working (Specify only highest grade completed) ondary (0-12) College (1-4 or 5+) event, t 17. Father's Name (First, Middle, Last) Be Ith and Mental F 27 is marked of traumatic ever 19a. Informant's Name/Relationship (Type 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health a Important: If item 27 is any injury or other trau once. 20a. Method of Disposition Burial 2 Cremation 4 Donatio Other (Specify) 23a. Part. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** cardiac disease or condition resulting in death) arre /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner as a consequence of) thrombotic The law requires that the death certificate be executed thrombocytopenic burial-trar Due to (or as a consequence of Box 68760, ate has been signed by the attending physician page 2 should be detached for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☐ onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 2 400 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA P 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: I or Attending F after death. 5 Pending investigation Injury 1 Tyes 2 🗌 No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 000 07-31-2009 lumma 30. Name and address of person with completed cause of death (Item 23a) (Type, Print)

101

State Registrar 31. Date filed (Month Day, Year) 32

HRISTINA

gistrar's Signature

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 03:25 am **Physician** 2009 VALERIE C. JONES /Medical (If not institution, give street and number 4b. City, Town, or-Location of Death 4c. County of Death 4a. Facility Name Examiner More N/AIf Under 24 Hrs. 5. Social Security 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Year **Funeral** Months Days Hours 1 M 28 MARYLAND 57 Director 213-60-0235 Feb. 10 1952 Usual Residence of Decedent 10d Inside City Limits 10a, State 10b. County 10c. City, Town or Location 28a-f shov item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 XYes 2 No Director BALTIMORE MARYLAND N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 44 N. KOSSUTH STREET U.S.A. 21229 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: BLACK 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) STATE OF MARYLAND 12th grade SECRETARY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILSON J HORTON SR CECILIA CURTIS ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fetus Jones II/ Husband Kossuth St., Baltimore, Maryland 21217 N. permit. Pages 1 a
Department of He
Important: If item
any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS MEMORIAL 08-07-09 BALTIMORE, MARYLAND 21. Signature 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. ueum 1206 W NORTH AVENUE Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) 0 01 /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): and Due to (or as a consequence of) the burial physician certificate be Physician/Medical attending p IF FEMALE: Box 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death ☐Yes 2 No been signed by the should be detached sion of Vital Records, P.O. 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 autopsy certificate 1 ☐ Yes 2 ☐ No 1 ∐Yes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes မ 1 Inpatient this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 5 ☐ Pending investigation Natural 1 □Yes 2 □No 2 Accident in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 200 Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Ime and address of person who completed cause of death (Item 23a) (Type, Print)

50

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician 215 BM RUSSELL ,2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NIA SI. BALTIMOR BRIGHTON If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours | Min. (Month, Day, 9. Birthplace (State or Foreign Country)
MARYLAND 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 **⊠**M 2□ F 217-16-8230 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location or 28a-f shov 1 Yes 2 □ No Funeral Director BALTIMORE MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural", or items 23a permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23s any injury or other traumatic event, Item Variant critical Expression of other traumatic event, Item Walfaal Expression of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event of the other traumatic event 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No If Yes, Give MAR 12,1943 Year or Dates: DEC. 28,1945 1 ☐ Never Married 2 Married 1 ☐Yes 2 No ≥ Specify: RLACK 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) WASHINGTON LOCAL BRICK MASON YEARS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SEFFRIES ZOHVI ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3301 Brighton St., BALTIMORE, MD 21216 J. JEFFRIES (WIFE) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State CARRISON FOREST CEM. 08/05/2009 OWINGS MILLS, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

SOSEPH H. BROWN JR. FUNERAL HOME 21. Signature of Funeral Service Licensee 2140 N. FULTON AVE, BALTIMORE, MD 2121; 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? Yes 2 100 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2) No 1∐Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Watural 1 ☐ Yes 2 ☐ No n 24 hours after death. e Funeral Director: /4 etely filled in by the fi 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Medical 1 🔛 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

Date filed (Month, Day,

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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of.			Registrar  1. Decedent's Name (First, Middle,	( act)		Jertincate or	Death	2. Date of Dea	Reg. No.	3. Time of Death
	Physicia	an	i. Decedent's Name (First, Miladie,	·		7 . 1		Month	Day Ye	ar
	/Medic		Anna	G.		Johnson		08	01 20	
3	Examin	er	4a. Facility Name (If not institution,	give street and number)		4b. City, Town, o	or Location of Death		4c. County of D	eath
	in a second contract of	- 6	Augsburg Luth	eran Nursi	ing Home		timore	0.0-4		
	Funeral			ADM AFT	e (In yrs. last birth	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	y, Year)	Birthplace (State or Foreign Country)
	Director		212-20-3485		33 Y	15.		09 1	1 25	MD
pue			Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
- A	sho	ō								1 X Yes 2 □ No
a d	28a-f	Director	MD NA  10e. Street and Number		ва.	ltimore 10f. Zip Code			10g. Citizen of What	Country?
with	ben	ä								
t d	s 23	Funeral	3202 Baker St	12. Was Decedent I	F		1216		U.S	• A • merican Indian,
pr de	item ner n	nu	11. Marital Status	Armed Forces?		<ol> <li>Was Decedent of F If Yes, specify Cub</li> </ol>	an, Mexican, Puerto	Rican, etc.)	Black, W	/hite, etc.
00 fe a	or ', or	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 🔯 Divorced	ed 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	10	1 ☐ Yes 2 No	Specify:		Specify:	Black
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Z K	thar thar	E C	Elementary/Secondary (0-12) 12th grade	College (1-4or 5	5+)	Dairy Bat	eriolog	ist	State o	f Maryland
ם ב	Hyg sther ent, t		17. Father's Name (First, Middle, L						Maiden Surname)	
מום	sed c	To Be	John Davage				Anna E	. Bank	s	
	mari mati	-	19a. Informant's Name/Relationsh	ip (Type. Print)	19b. I	Mailing Address (Street	and Number or Rui	ral Route Numbe	er, City or Town, Sta	e, Zip Code)
Mai	Ith all		Michelle Doug	lac-Daugh	tor 320	2 Baker S	treet.	Baltim	ore. Md	21216
בי ב	of Health ar		20a. Method of Disposition	Tas-Daugiii	20b. Place of D	Disposition (Name of	i	Date	20c. Location - City	or Town, State
Dallimor	t: If i		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp			crematory or other pla		0/09	Pikesvi	llo Md
	artme ortan		21. Signature of Funeral Service L		Dru	id Ridge 22. Name and Addre		0/09	FIKESVI	IIe, Mu
ם פ	penill. Tages I and 2 should be received within 12 hours are recent with the maryand important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		77	K- Jane	)	March F/	'H West	D - 1 h	M	2 21215
it.			23a. Part1. Enter the disease, or	complications that caused	the death. Do no	4300 Wab				Approximate
			shock, or heart failure. List of Immediate Cause (Final	only one cause on each lin	ne.		_			Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death)	a	a consequence of	COPT				years
	xaminer			Due to (or as	a consequence of	).				/
Š.	-5	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as	a consequence of	i):				
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- d	d for	ician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant at	2 Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	гу		23d. Date of Month	delivery Day Year
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Catherine Jones July 28 2009 04:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Greater Baltimore Medical Center Towson If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, 6. Sex **Funeral** Age (In yrs. last birthday) Months 1 □ M 2 🛛 F Days Hours 91 Director 200-05-5152 July 3, 1918 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No other traumatic event, the Medical Examiner must be notified Director Maryland | Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or items 23a 211 Brackenwood Court 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 📉 No Specify: White ģ Specify 3 X Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hyglene. ant: If item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Maryland 21 12 02 Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Collins Zellers Russell Wilson Marguerite 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tr Dr. Collins Jones/Son 20522 Amethyst Lane, Germantown, MD20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of h Burial 2 Cremation 3 Removal from State 2009 ation 5 Other (Specify) Dulaney Valley Memorial Gardens Timonium, Maryland 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road. Timonium. MD 21093 W. Clary Bryan sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, th line. 23a. Part1. Exter the disease, or complication that ca shock, or hear failure. List only one cause on ear Immediate cause ( inal disease or c addit n resulting in death) **Physician** Sepsi /Medical Due to (or as a consequence of): Examiner ischemi mesenteric Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Box 68760. physician Physician/Medical as nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy for Month Year Day Pregnant at time of death 5 Other (specify) 1 □Yes 2 No 9 Unknown detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2 ☑No filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Division of Vital Records, Hospital or Attending Physician: within 24 hours after deat To the Funeral Director:

Registrar

Medical

29a. Certifier

(Check only one)

Kolyardo 31. Date filed Month, Day,

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

completely

Falcon

Kdvardo

, M.D.

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0060721

29d. Date signed (Month. Day. Year)

2009

Heartland of Adelphi Adelphi If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Dec 19, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1⊠ M 2□ F Months 1942 66 Director 880-86-8477 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Mastical Evaluation and the controlled at once. 10a. State 10b. County 10c. City, Town or Location Funeral Director Washington, DC Washington, DC 10g. Citizen of What Country? 10e Street and Number 10f Zin Code USA 20037 900 23rd Place 12. Was Decedent Ever in U.S. Armed Forces?unk
1 □ Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk 1 □Yes 2 □ If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1X Yes 2 □ No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation **un** (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Unit 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heartland of Adelphi 1801 Metzerott Road; Adelphi, Maryland 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) In State 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Service Licensee Ronald S. Wage Director **Physician** /Medical Due to (or p a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> Be Completed 24a Was an autopsy U 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending investigation death. 2 Accident

and manner stated.

32. Registrar's Signature

amend #4c Per Ana Bd G894 8/06/09 JH
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

4b. City, Town, or Location of Death

23d Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 2 No Other: 4 Unursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 7.27.2009 30. Name and address of person who completel cause of death (Item 23a) (Type, Print) 10810 DARNES TOWN Road. Swite TULLI. MI 202

Reg. No.

Pay

2006

4c. County of Death George's

14. Race - American Indian,

Specify: hispanic

unk

Approximate Interval Between Onset and Death

Black, White, etc.

9:00 P

10d. Inside City Limits 1 ☐ Yes 2 ☑ No

2. Date of Death July

State Registrar 1 - For State Registrar

**Physician** 

/Medical

Examiner

1. Decedent's Name (First, Middle, Last)

Heriberto Jimenez

4a. Facility Name (If not institution, give street and number)

6 □ Could not be

man

AUG U 4 2009

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

after death Director;

24 hours a

To the within 2

completely filled in by the

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 17, **Physician** 2009 10:35 AMM Francis A. Jacobi /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5637 Purdue Avenue #D Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number UNK 6. Sex Birthplace (State or Foreign Country) unk 7. Age (In yrs. last birthday) **Funeral** May 16, 1926 Director 83 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Iteme 23s or 28s-f show the Medical Examiner must be notified at X□Yes 2□No MD Baltimore Baltimore City Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21239 5637 Purdue Avenue #D 12. Was Decedent Ever in U.S. Armed Forces? unk 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status unk Black, White, etc. 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 Yes 2X No Specify: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation UNK (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Unk within 72 ! nd 2 should be filed within 7 alth and Mental Hygiene.
27 ie marked other then "r rraumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) unk Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)unk permit. Pages 1 and 2.2 Department of Health at Important: If Item 27 ie eny injury or other trau Officer Sinkler/BCPD 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 Nother (Specify) in State wice Licensee 21. Signature of unera Conal 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street in Baltimore, Maryland 21201 23a. Part. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulling in death) Myocardia Physician day /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner led by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown cate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Š 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were aulopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an After this certificate has funeral director, page 2 s autopsy performed?

1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification; or Attending 1 Natural 2 Accident 5 Pending To the Hospital or Attendia within 24 hours after death.
To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No М investigation 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certified DO052583 July 27, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lock Raven Blad. Baltimere, MD 21239 lavid I. Naiman ino 5601 31. Date filed (Month, Day, Year) 32/Registrar's Signature State AUG 0 4 2009 Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Time of Death Dav Month **Physician** 30 2009 :104 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner timory Date of Birth (Month, Day, 9. Birthplace (State or Foreign last birthday **Funeral** Director with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 ☐ es 2 ☐ No Director MD ltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. int: if item 27 Is marked other than "natural", or items 23s ury or other traumatic event, the Medical Examiner must 14. Race Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 9 lad 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DQ NOT use retired) College (1-4or 5+) Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) Be ( 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 1 Burial 2 ☐ Cremation permit. Page Department o Important: if any injury or 3 Removal from State 5 Other (Specify) 4 ☐ Donation 21. Signature of Funeral Service Li 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SWD **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death the detached 9□Unknown 9 ☐ Unknown ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 3 Probably 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an certificate has 1∐ Yes 2 No Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 ☐ Pending investigation 1 Natural Injury 1 Yes 2 No 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Funerai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only and manner stated. To the I To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

5 V

State Registrar 8813 ar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death	Reg. No.
				2. Dete of Death Month Day Year 3. Time of Death
-	Physici /Media		John C. Keus	August 1,2009 4:05 M
.7	Examir		4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Loc	ation of Deeth 4c. County of Death
	,		5 Social Security Number 6 Sex 7. Age (In vis. last birthday) If Under 1 Year If Under 24 Hrs.	Nore // / / / / / / / / / / / / / / / / /
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs_last birthday) 17. Age (In yrs_last birthday) 17. Age (In yrs_last birthday) 18. Months Days Hours Min.	8. Date of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign Sountry)
	101-1		Usuel Residence of Decedent	you. s, i is i i ai grana
	nyland how		10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	Ba-f s	cto	Nd. NA Baltimore	1M Yes 2□No
	vith th		10e. Street end Number 10f. Zip Code	10g. Citizen of What Country?
	se 23	Funeral Director	11. Merital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec	ify Yes or No- 14. Race - American Indian,
	fter d	Fun	Armed Forces? If Yes, specify Cuban, Mexican, Puerto R	ican, etc.) Black, White, etc.
070	urs a	by	If Yes, Give 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	Specify: Black
21215-0020	filed within 72 hours after death with the Meryland Hygiene. ther than "natural", or frams 23a or 28e-f show that the Medical Examinet must be notified at	Completed by	15. Decedent's Education 16a. Decedent's Usual Occupetion (Specify only highest grade completed) (Give kind of work done during most of working the completed)	16b. Kind of Business/Industry
121	Man.	ID I	Elementary/Secondary (0-12) College (1-4or 5+)	Acquitte Mataca
	Hygie Hygie ther t	ပ္ပ	17. Father's Name (First, Middle, Lest)  18. Mother's Name	(First, Middle, Maiden Surname)
an	id be ental ked o	To Be	Griffin Kous Stell	a Conner
Maryland	2 should be filed with end Mental Hygiene is marked other than aumatic event, treas	-	19a. Informant's Name/Relationship (Type, Print)   nephew   19b. Mailing Address (Street and Number or Rural	Route Number, City or Town, State, Zip Code)
	1 and 2 Heelth e em 27 is		Mr. Dennis Keus 5319 Bosworth A	ve. Balto. Md. 2/207
ore	of He		20a. Method of Disposition  20b. Place of Disposition (Name of cametery, crematory or other place)  3 □ Removal from State	Date 20c. Location - City or Town, State
Ë	. Pages ment of I tent: if Ite jury or o		4 Donation 5 Other (Specify)   Weto Crematory	112009 Balto, M.d.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Merylan Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show wayl injury or other traumatic event, the Medical Extrainer must be notified at ance.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Joseph L. Russ Fu	neral Home, P.A.
	ED = G G		Jeogel A- Truck 2222 W. North Ave	Balto, Md. 21216
No. of			23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shipck, or heart failure. List only one cause on each line.	respiratory arrest, Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition AGGVD	
, E	Examiner		disease or condition resulting in death)  Due to (or as a consequence of):	
	D .=	ner		
	es that the death certificate be executed igned by the attending physicien and be detached for use es the bunel-trensit	Examiner	Sequentially list conditions, if any leading to immediate	
60,	be ex	aE	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events  Due to (or as a consequence of):  Due to (or as a consequence of):	
68760,	ficate physis the	edlcai	resulting in death) Last  Due to (or as a consequence of):	
Вох	nding use e	M	d	
	death e atte	sicia	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death?
P.0	of the dby the stack	Physician/N	HIN	1 ☐ Yes 2 ☐ No 3 ☐ Probably ♣☐ Unknown
	The law requires thet the death cer ete hes been signed by the attendin page 2 should be detached for use	þ	2 . 1	24h Ware outgooy findings
Ö	v require been si should t	eted	CVA	24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause
Rec	hes t	Completed		of death?
Vital Records,	iclan: The certificete rector, pag		25. Was case referred to medical 26. Place of Death	1 Yes 2 No
Ž	Physician: r this certific ral director,	To Be	examiner? Hospital:	te 5 ☐ Residence 6 ☐ Other (Specify)
n of	g Phys ter this neral d		27. Manner of Death 1 Properties 1 Properties 1 Properties 1 Properties 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 2 Work? 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury	8d. Describe how injury occurred
Sio	Attanding or death.  sctor: After by the fune	catic	2 Accident investigation M 1 Yes 2 No	
Division	or Attending lefter death. Director: After in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attanding Physician: The is within 24 hours effer death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	2	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an	nd due to the cause(s) and manner as stated.
	To the Hospital within 24 hours To the Funeral completely filled	edicai	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and menner stated.	
_	To th To th comp	M	29b. Signature end title of certifier 29c. License number	29d. Date signed (Month, Dey, Year)
			17 Mult Zeel M() D39/2/	8/3/2009
			30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)	
	22 22 3		821 N' Eulaw 57 Balli More M 2 20 1  31. Date filed (Month, Day, Year)  32. Registrar's Signature	
*	Sta Registr	-	AUG 0 4 2009 Chow B. parket	

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2009 July 7:40 A M 30 Mary Angela Kilduff 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death N/A Joseph Ritchey Hospice Baltimore 8. Date of Birth (Month, Day, Ye Oct. 20, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) Days Months Hours 1923 Maryland 219-16-9696 85 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h County 1√ Yes 2 No MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3671 MacTavish Avenue 21229 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married 1 □ Yes 2 □ X o Specify. Specify: White If Yes, Give Year or Dates: 3 ☐ Widowed 4 🎇 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Secretary **Healthcare** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry Shea Margaret Spoerer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Michael J. Kilduff - Son 1224 Ten Oaks Rd., Baltimore, MD 21227 20b. Place of Disposition (Name of conselery, company on other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Degriel 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) Gemeterv 8-1-2009 Baltimore, MD 22. Name and Address of Facility Ambrose Funeral home, Inc. signature of Funcial Service Lic-ins-e 1328 Sulphur Spring Rd., Arbutus, MD 21227 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final prove disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? Month 1 □Yes 2 KNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Cancos 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 □Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Mapner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State)

/Medical Examiner physician and s the burial-trans attending p page Division of ospital or Attending hours after death. neral Director: A To the ... within 24 hours ... To the Funeral Di

Physician/Medical Completed Be မ Certification: Medical

**Physician** 

/Medical

Examiner

Director

Funeral

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Director

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filed within 72 hours after death with 1 Hygiene.

and 2 should be filed within lealth and Mental Hygiene. m 27 is marked other than '

Health tem 27 i

permit. Pages 1 and Department of Healt Important: If item 2: any injury or other t

**Physician** 

Baltimore, Maryland 21215-0036

Natural 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier eallle

29c. License number 1)33.400 29d. Date/signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

6301 N Charles Street Baltimores MD 21212 Iglehart TI 4D 32. Registrar's Signature 31. Date filed (Month, Day Year,

State Registrar

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Division of Vital Records, P.O. Box 68760,	To the Hospitel or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and	completely filled in by the funeral director page 2 should be detached for use as the burial-transit

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To t with To t	Σ	29b. Signature and title of dertifier	CENP					e number	2			signed (Moni	th, Day, Year)	
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# Baltimore, Maryland 21215-0036

1 - For State Registrar

Division of Vital Records, P.O. Box 68760, &

Physicia	an.	Decedent's Name (i									2. Date of D	/ Da	y Yea	ır	3. Time o	Death  15 M
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Examin	er	4a. Facility Name (If no	ot institution,	give street and nu	ımber)		4b. City,	Town, or	Location	of Death		4c	. County of De	eath		
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Funeral		<ol><li>Social Security Num</li></ol>		6. Sex 1. 1. M 2. □ F	7. Age (In yrs.		If Unde Months	r 1 Year Days	If Under Hours	Min.	8. Date of B (Month, D	rth ay, Year)	9. 6	Birthpl Co <i>unt</i>	ace (State ry)	or Foreign
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, it a Medical Evantary court be multified a sone.		21. Signature of Fune	eral Service Li	icensee Amaro	la Heastor	$\mathbf{n} \mid \mathbf{r}$	22. Name a	nd Addre	ss of Facil	lity Cre	mation S	3cciet	y of Man	cyla	nd, In	c.
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To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.		29a. Certifier 1 (Check only 2	Certifying  Medical E	Physician: To the xaminer: On the	e best of my kno basis of examina	owledge, dea	ath occurre	d at the ti	me, date a	and place	, and due to the	ne cause(	s) and manne	rass	tated.	(s)
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6		30. Name and addres	s of person w	vho completed cau	ise of death (Iter	m 23a) (Type	Print)	, 1			Ocil.				1200	
2		30. Name and addres		n Bur	TONIO	2835	Smit	U A	venu	/6	ZULTIM	WIE	IVLU	-	1207	
Sta		31. Date filed (Month	Day, Year)	32.	Registrar's Signa	ature										
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

24815

Reg. No. 2009

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2009 31, 10:35A™ Julv 4c. County of Death 4a. Facility Name (If not institution, give street and number) NA Baltimore Future Care Irvington If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country Un K • 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days 1 □ M 2 🗓 87 220-14-3208 02 - 19 - 22Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City. Town or Location XXYes 2□No Baltimore MD NA 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21229 USA 22 South Athol Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. African 1 X Never Married 2 ☐ Married 1 □ Yes 2 No Specify: Specify: American 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) NA Domestic Homes 18. Mother's Name (First, Middle, Maiden Surname) Unk. 17. Father's Name (First, Middle, Last) Unk. 19a. Informant's Name/Relationship (Type. Print) Social 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 South Athol Avenue Baltimore, MD 21229 Rosalind Githara Worker 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MT. Zion Cem. 08-04-09 Lansdowne, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 □ Yes 2 □ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work?

**Physician** /Medical Examiner Examiner be executed

Physician

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

by Funeral

Completed

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If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the "Modeal Extra hard ruist be not the

"natural", or

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n, any injury or other traumatic event, the Mental once.

Baltimore, Maryland 21215-0036

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Physician/Medical

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Certification: To

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P.O. Box 68760,

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neral Director; A
filled in by the fu death.

To the Hospital or Attending Physician: within 24 hours a

State Registrar 27. Manner of Death 1 Natural 2 Accident

4 - Homicide

29a. Certifier

5 Pending investigation 3 ☐ Suicide

6 ☐ Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

PHYSICIAN

29c. License number 57543 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1940 W. BALTIMORE ST. BALTIMORE MOSISES

SANDHV 31. Date filed (Month, Day, Year)

32 Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2009 July Physician 22, 9:00 PM M Frances Alice Kleeman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 818 W. 40th Street Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | U1y 22, 1918 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 1 F 005-18-2166 91 Yrs. Director Usuel Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a State 10b. County 28a-f show traumatic event, the Medical Examiner rount be notified at MD Baltimore 1X Yes 2 □ No Baltimore City Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 238 818 W. 40th Street 21211 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩNo If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☒ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industrunk 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) grade completed) Elementary/Secondary (0-12) College (1-4or 5+) translator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Arthur S. Kleeman Alice Pentlarge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 818 W. 40th Street; Baltimore, Maryland 21211 Elizabeth Frank/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Lonald S. Warden State Anatomy Facility Board 655 W. Baltimore Street Director Baltimore, Maryland 21201 Approximate Interval Between Onset and Death 2.5 YEARS 23a. Part \Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SQUAMOUS CARCINDIMA CELL Physician /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physicien and hed for use as the burial-transit The law requires that the deeth certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð certificete has been signe rector, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 2 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) #OSPICE 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending aftar death. 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Dey, Year) HYSICIAN D0047832 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10757 LUN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

AUG 0 4 2009

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barker

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. importent: If Item 27 is marked other then "naturel", or iteme 23s or 28s-f show any injury or other treumatic event, if a Medical Evaluation must be notified at once.

Baltimore, Maryland 21215-0036

Funeral Director

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760, To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

al .	Linda Joyce Kl	ebe				July 11	2009		7:00 PM M			
	4a. Fecility Name (If not institution, give	e street and number)		4b. City, Town,	or Location of Death		4c. Count	y ol Death				
	7885 Gordon Co	urt #581		Glen B	urnie		Anne	Anne Arundel				
	5. Social Security Number 6. S 218-42-2335	ex 7. Age (li	n yrs. last birtl	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Oct 2,	h	9. Birtho	lace (State or Foreign try) 1essee			
	Usual Residence of Decedent											
101	MD 10a. State 10b. County Anne Art		oc. City, Town					1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No			
ě	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	itry?			
5	7885 Gordon Court	· #581		21061			USA					
e	11. Marital Status	12. Was Decedent Eve	r in U.S.	13. Was Decedent of If Yes, specify Cub		ecify Yes or No-		ce - Americ				
by rur	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 Yes 2 No Il Yes, Give Year or Dates:		If Yes, specify Cub		Hican, etc.)	)	<sub>fy:</sub> white.				
lo Be Completed by Funeral Director	15. Decedent's Ed (Specify only highest gra	Jucation ide completed)	16a.	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of worki	ing	16b. Kind of E	Business/Inc	dustry			
E COM	Elementary/Secondary (0-12)	College (1-4or 5+)		waitress			food i		ry			
G	17. Father's Name (First, Middle, Last)				18. Mother's Name		Maiden Suma	me)				
0	James Moran Rhoad	les			Mary P	ickard						
	19a. Informant's Name/Relationship (			Mailing Address (Stree				, State, Zip	Code)			
	Patricia D. Dolar			Box 54; Ca		ryland		6' · · T	·			
	20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ※ Donation 5 ☐ Other (Specification 2)	Removal from State	cemeter	Disposition (Name of y, crematory or other pla		Jete Jete	20c. Location	- City or To	own, State			
	21. Signature of Funeral Service Licer Ronald S. V	Jede Direct	or	22. Name and Addr State Anat	omy Board		Baltim	ore S	treet			
-	23a, Part1. Enter the disease, or com	plications that caused the	e death. Do n	Baltimore	no such as cardiac o	or respiratory ar	rest.		Approximate			
	shock, or heart failure. List only	one cause on each line.	1	O > O	0		1.00-	-5	Interval Between Onset and Death			
	Immediate Cause (Final disease or condition resulting in death)  A CHRONIC OBSTRUCTIVE FULLMONARY DIRECTION AREA (CHRONIC OBSTRUCTIVE FULLMONARY DIRECTION AREA (CHRON											
	shock, or hear failure. List only one cause on each line.  Immediate cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate  Interval Between Onset and Death  CHRONIC OBSTRUCTIVE FULMONARY DISEASE  Due to (or as a consequence of):  Due to (or as a consequence of):											
	Sequentially list conditions,  b. Due to (or as a consequence of):											
<u>e</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury											
	that initiated events	с										
Ĭ	resulting in death) Last	Due to (or as a co	onsequence o	of):								
Ca	•	_ d										
5												
all V	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p		3 ☐Ectopic pregnanc	Ey			ate of delive	ary Day Year			
nysician/medical Examiner	1 Yes 2 No 9 Unknown	4□Pregnant at tim 9□Unknown	e ol death	5 Other (specify)				Ontri	July 1 Gal			
Completed by P.	Part II. Other significant conditions of	contributing to death but a	ot resulting in	the underlying cause g	ven in Part I.	23e. Did to	bacco use con	tribute to th	ne cause of death?			
2		TXPON -	DASE	-TES		101	'es 2□No	3 Prob	ably 4 Unknown			
910		1/1				24a. Was	245	Mara auto	and findings available			
E						autoc	SV	prior to co	psy findings available mpletion of cause of			
3						1 ☐ Yes	rmed? 2 ☐ No	1 Yes	2 No			
0	25. Was case referred to medical example;?				26. Place of Deatl	h (Check only o	ne)					
2	1 🗹 Yes 2 🗆 No	Hospital: 1 Inpatient	2 ER/Out	tpatient 3□ DOA O	her: 4 Nursing Ho	me 5 Resid	tence 6 □Ot	her (Specif	y)			
ation:	27. Manyler of Death  1 Natural 5 Pending  2 Accident investigation	28a. Date of Injury (Month, Day Yo	ea <i>r)</i> 28b. T	njury Wo	ıryat ork? ]Yes 2 □No	28d. Describe h	now injury occu	rred				
Medical Certification: 10 Be	3 Suicide 6 Could not b		- At home, fai Specify)	rm, street, lactory, office		28l. Location (5 City or Tox		ber or Rura	al Route Number,			
GICAL	29a. Certifier 1 Certifying Pt (Check only one)	nysicien: To the best of n miner: On the basis of ex and manner stated	amination and	, death occurred at the td/or investigation, in my	ime, date and place, opinion, death occur	and due to the red at the time,	cause(s) and m date and place	anner as s	tated. the cause(s)			
Me	29b. Signature and title of certifier	005	e	29c. Licen	se number	1	29d. Date sign	ed (Month,	Day, Year)			
	r · care		1	100	1 WDI	9	ip	-11 "				
	30. Name and address of person who Anil Chopra 7	completed cause of deat		Type, Print) <b>Glen Burni</b>	e ,MD 210	61	1	,				

3. Time of Death

State

Registrar

31. Date filed (Month, Day, Year)

AUG 0 4 2009

park

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 10:05 PM KIRKPATRICK JUly 27 FAY 2009 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Saltimore JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday, Year) Days Hours Min 245-01-3165 North Carolina Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 🔼 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces?
1 [Yes 2][No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 ☑No Specify: Why 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Nursing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cleveland Hollars Hattie Cook 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 719 Margo Rd. Dundalk, Maryland 21222 Chesley Kirkpatrick (son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Hilltop Service Corp. 08/03/2009 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Duda-Ruck Funeral Home of ture of Funeral Service Licenses 7922 Wise Ave. Dundalk, MD. 21222 Dundalk, Inc. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Immediate Cause (Final CARDIO PULMONARY ARREST 10 MINUTES disease or condition resulting in death) Due to (or as a consequence of): 4 DAYS Ischemic stroke Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

Physician /Medical Examiner

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physician the burial

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certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Box 68760,

P.0.

of Vital Records,

Division

the death certificate be

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Physician/Medìcal

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Completed

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Certification:

Medical

State

Registrar

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Extr. divernment by purfitted 21 once.

Saltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

☐Yes 2☐No 9 Unknown

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural

5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient

2 ER/Outpatient 3 DOA 28h Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

2 Accident

4 Homicide

3 Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

29b. Signature and title of certifier

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MD

JULY 27, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital

John C. Probasco, M.D. 31. Date filed (Month, Day, Year)

4940 Eastern Avenue Registrar's Signature

M.D.

Baltimore

2. Date of Death

Certificate of Death

3. Time of Death

Physician
/Medical
Examiner

1 - State Registrar

1. Decedent's Name (First, Middle, Last)

Box 68760,

Division of Vital Records, P.O.

Baltimore, Maryland 21215-0036

Month Day Year Bernadine J. Kulik 8:00 Am Ju1y 31. 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Co. 1200 Grafton Shop Road Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 30,1932 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2**X** F 218-28-3470 Yrs Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show event, the Medical Examiner must be notified at Director Bel Air 1 ☐ Yes 2 TNNo Harford Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1200 Grafton Shop Road or items 23a 21014 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates þ Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event, In a Modis once. (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Cafeteria Worker 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maryanna Fisher ပ James Gardner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1200 Grafton Shop Road Bel Air, MD Mr. Edward Kulik (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gdns. 8/5/2009 Middle River, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
Dundalk, Maryland 21222 21. Signature of Funeral Service Licensee Dundalk, Maryland 7922 Wise Ave. part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset *a*nd Death Immediate Cause (Final LANLAI Wenst **Physician** YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burdar-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 ☑No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 88 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bel An MS 21019 415 W-MACPHAIL RD LERRO /32. Registrar's Signature 31. Date filed (Month, Day, Year) State 4 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #2 per MD 8894 8/4/09 III
State of Maryland / Department of Health and Mental Hygiene 0 0 0 Certificate of Death 30, 2009 Time of Death 2. Date of Death July 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 3:45 PM LE<sub>0</sub> KAHAN May 1922 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Hospital of Baltimose city N/A f Under 24 Hrs. I 8 8. Date of Birth 05/02/1922 9. Birthplace (State or Foreign 5. Social Security Number (In yrs. last birthday) 87 Yrs. **Funeral** Months 1 X M 2 □ F LITHUANIA 214-30-3073 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State Department of Health and Mental Hygiene important: if item 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantinar must be notified at once. 1 ☐ Yes 2 XNo BALTIMORE BALTIMORE Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21208 1317 ST. ALBANS ROAD USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 X No Specify: WHITE ۾ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Rhown as 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) EXECUTIVE PAINT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ABBA KAHAN FRIDA PLEIN ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7105 DEERFIELD ROAD BALTIMORE, MD 21208 ELINOR SKLAR / SISTER-IN-LAW Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition Date Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW CEM: 08/02/2009 REISTERSTOWN, MD 4 Donation 5 Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acuto Acute Respiratory failure
Due to (or as a consequence of):

Malignant Efficien (Pleural)
Due to (or as a consequence of): **Physician** day /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: he law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the chould be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> dependent 1 ☑Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ NO Hypertension 24a. Was an certifica e has rector, p. ge 2 st autopsy performed? 1 □Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: this t Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1☑Inpatient 2☐ER/Outpatient 3☐DOA Medical Certification: To within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Watural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Res 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abraham Hospital MBB 31. Date filed (Month, Day, Year) 22. Registrar's Signature State AUG U 4 2009 Registrar

Marcella Lawson 09-06017

**UNK UNK** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 24822

		1- For State Certificate of Death Reg. No.					
Physiciar Iedical Examin	1/	1. Decedent's Name (First, Middle, Last)  August 2. Date of Decedent's Name (First, Middle, Last)  August 2. Date of Decedent's Name (First, Middle, Last)				3. Time of Death 0524 hrs	
	4	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of  2800 block of Edgecombe Circle  Baltimore		7.109=01=1	4c. County of E	Peath , N/A	
	٠,	2000 block of Edgocombo Guido	r 24Hrs	8 Date of Bir	th/MM/DD/YYYY) 9	I. Birthplace (State or	
Funeral Director	212-42-1223 1 M 2 F 64 Yrs. Months Days Hours Min. Nov. 19, 1944 Foreign Country) M.					oreign Country) Mary and	
· &	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside						
Varyland 28a-f show any d at once.		Maryland N/A Baltimo	ore		0g. Citizen of What	1 Yes 2 No	
tth the Mary 23a or 28a notified at	D E	10e. Sfreet and Number 10f. Zip Code 21201	1		U U	SA .	
≽ ≅ a	σı	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Original In Yes, specify Cuban, Mexican,			White, e	American Indian, Black, etc. Slac V	
hours after 'natural'', Examiner	<u>a</u> -	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give k	kind of wo	ark done	Specify: 16b. Kind of Busin	ness/Industry	
136 hin 72 hours e. than "natu	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)	use retire			of Mayland	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medics	Be Com	17. Father's Name (First, Middle, Last) 18.Mother's	's Name (		Maiden Surname)		
21215-00 uld be filed wit Mental Hygien marked other c event, the M		George Perkins The	Ima	Brown			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical	٥	19a. Informa s Name/Relationship (Type, Print)  George Lawson - Musbard  19b. Mailing Address (Street and Number of Soft Harlem Ar	nber or Ru	Beth	mber, City or Town, Mai	State, Zip Code) 21201	
ore, MEss 1 and 2 si of Health an If item 27 her traums	Ī	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	,	Date	20c. Location - C	ity or Town, State	
altimore, mit. Pages 1 a partment of He pportant: If ite		4 Donation 5 Other Specify: Arbutus Mem. Hark	8/12	409	Hrbut	15, Maryland	
Baltimo permit. Page Department. Important: injury or ot	-	21. Signature of Fund Service Lionne 22. Name and Address of Facility 3512 Frederick	Ave	- Fur Bay	timore,	re P.A. 21229	
Physician							
/Medical xaminer		Immediate Cause (Final disease a, Gunshot wounds (2) of head Death					
		or condition resulting in death)  Due to (or as a consequence of):					
	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):					
ed	Examiner	(Disease or injury that initiated events resulting in death) Last   C. Due to (or as a consequence of):					
		UNPENDED AMENDED					
50, te be a	led.	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of de	elivery	
A 4 CD 70	盲	23b. Was decedent pregnant in the past 12 months?	c pregnan	псу	Month	Day Year	
Box 68760 e death certificate be the attending physicate by d for use as the bu	UNPENDED  AMENDED  AM						
the de ched f	좕	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	art I.	23e. Did	tobacco use contribu	ute to the cause of death?	
P.O.				1 Ye	es 2 🗸 No 3	Probably 4 Unknown	
ds, equire	Completed by			24a. Was		ere autopsy findings available	
COr law r has b	립				ormed? de	or to completion of cause of ath?	
tal Recian: The certificate		25. Was case referred to medical 26.Place of Death	(Check o		2 No 1	Yes 2 No	
Vital Records, spician: The law requirents his certificate has been a director, page 2 should	o Be	examiner?   Hospital:   Innation: 2   ED/Outpatient 3   DOA   Other;		Home 5	Residence 6 🗸	Other: Scene	
n of Vital Records, ing Physician: The law requiring After this certificate has been is funeral director, page 2 should be	-1	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work			how injury occurred	1	
sion ttendin death. ctor: A y the fur	힑	1 Natural 5 Pending FOUND: Pov.Year) FOUND: 1 Yes 2 🗸	No	Subject sh	οτ		
[로.북.일 <b>군</b>	Certification:	2 Accident Investigation 3 Suicide 6 Could not be Could not be				or Rural Route Number, City	
Divis	팅	4 V Homicide determined (Specify) Park 2800 Block of Edgecombe Circle North, Baltimore, MD					
	Medical						
FSER	ž	29b: Signature and title of certifier 29c. License number				(Month, Day, Year)	
		all 11 1 1 CO.C.M.E.			August 2, 20	009	
21	t	30. Name and address of person who completed cause of death (Item/23a)	MD C11	204			
JV		Zabiullah Ali, M.D. Assistant Medical Examinér 111 Penn Street, Baltimore, N	MD 212	201			
Sta Registi		31. Date filed (Month, Day, Year)  32. Régistrar's Signature  AUG 0 4 2009					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 24823 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year 1630 2009 Annie Ruth Lundy JUL 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Northwest Hospital Randallstown 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 052-24-2714 1 □ M 2 X F 7/18/1930 SC Usual Residence of Decedent 10d. Inside City Limits 10a. State M D 10b. County 10c. City. Town or Location 1 X Yes 2 No Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2203 Roslyn Avenue 21216 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 ▼No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 ☑ No Specify. Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elijah Priester Annie P. Goodwin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2203 Roslyn Avenue, Baltimore, Maryland 21216 John McKinley Lundy 20a. Method of Disposition

1 Disposition 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 8/06/2009 Owings Mills, MD Garrison Forest 22. Name and Address of Facility Wylie Funeral Homes of Baltimore County 21. Signature of Funeral Service Licenaee 9200 Liberty Road, Randallstown, Maryland 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Plastic Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter the refing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 I Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

Be

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**Funeral** 

**Director** 

Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

72 hours after

d 2 should be filed within 7 th and Mental Hygiene, 7 is marked other than "r

1 and 2 s Health ar tem 27 is

permit. Pages 1 and Department of Healt Important: If Item 2: any Injury or other: once.

Baltimore, Maryland 21215-0036

tran and physician at s the burial-t as the the attending nse detached for signed by t page 2 should peen has certificate

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Examiner Physician/Medical <u>۾</u> Completed Be Certification: To

27. Manner of Death

1 ☐ Yes 2 No

31. Date filed (Month, Day,

1 🕍 Natural

3 Suicide

29a. Certifier

2 Accident

4 Homicide

After this certification funeral director, p

To the Hospital or Attending Physician; death. reral Director; A after within 24 hours a

State Registrar

Medical

29b. Signature and title of

5 Pending investigation

6 Could not be

determined

28a. Date of Injury (Month, Day, Year)

and manner stated

H45931

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Nother (specify)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835 Smith Avenue Baltimas MD Registrar's Signature 32.

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2009 Lewis H. McKnight August 11:03 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 3814 Proctor Lane Baltimore Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours Months 1 □M 2 □ F 83 Yrs May 25,1926 Massachusetts Director 219-28-8151 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a, State other than "natural", or items 23a or 28a-f show vent, the Wedical Exercises must be notified at 1 ☐ Yes 2 No Director Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21236 3814 Proctor Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Beneficial Finance Elementary/Secondary (0-12) Finance Manager 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill if Health and Mental Hitem 27 is marked oth other traumatic even Be Mary Heron Lewis H. McKnight ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3814 Proctor Lane-Baltimore, Maryland 21236 Margaret McKnight-spouse permit. Pages 1 a Department of He 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Important: If its any Injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aug. 4, 2009 Timonium, Maryland Dulaney Valley Memorial
Memorial
And Address of Facility 21. Signature of Funeral Service Licensee 8800 Harford Road Evans Funeral Chapel and Cremation Services Parkville,MD 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) both /Medical Due to (or a a consequence of): Examiner TAI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ner Physician; The law requires that the death certificate be executed Exami burial-tran Due to (or as a consequence of): nding physician are as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? atten for u Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.0. 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗷 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10.11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sottenfield 515 FAIT mes next owson 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#10c&17perFH, G894, 8/4/09, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 . Month **Physician** Maggie Moore Inlu /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City-Town, or Location of Death Examiner ITAL A NB He MOICE Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Nov 3 19 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours Months Min. 213-20-8800 1 □ M 2 🕱 F 90 Nov S.C. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show or other traumatic event, the Medical Examiner must be notified at MD Baltimore Baltimore 1 ☐ Yes 2 No Director Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code within 72 hours after death with 815 Winters Lane 21228 USA #206 items 23a Funeral 14, Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Black Specify Specify: <u>Ş</u> 3 Midowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Domestic Worker Private 5th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Heatth and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event Be Tony Caroline McKnight McFadden ပ Toney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Columbia, MD 21045 James Jones - Son 8760 Endless Ocean Way 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State Baltimore National 8-5-09 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 4300 WaBASH Ave. Inc. Baltimore MD 21215 March Funeral Home West, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Myocardial **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for se's consequence off Examine use as the burial-transi Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? Month Year 5 Other (specify) P.O. | signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No Completed Were autopsy findings available prior to completion of cause of death? cate has bage 2 s autopsy perform certificate 2 No 1 ☐ Yes 2 ☐ No 1 □ Yes Division of Vital To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to edical examiner? Be 26. Place of Death (Check only one) 2 [⊒No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal (Check only one) and manner stated 29b. Signature and title MI 30. Name and add ss of person wild completed cause of death (Item 23a) (Type, Print) Maryland 21229 900 Caton Abounce 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death 31<u>,</u> 2009 July 3:07 A.M Alice Berteal Matthews 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 □ M **%** ▼ Yrs. 216-20-8987 82 21 1927 Maryland Apr. Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland N/A Baltimore X Yes 2 □ No 10f. Zip Code 21 21 7 10g. Citizen of What Country? 10e. Street and Number 701 N. Arlington Avenue#307 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: Black 1 □Yes 2√□No 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) City of New York Elementary/Secondary (0-12) College (1-4or 5+) Clerical Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mayon Matthews Alice Redd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Shelton/Sister 6421 Washington Ave 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/09 Brooklyn, Maryland Mt. Calvary Cemeter 21. Signature of Funeral Service Licensee Chatman-Harris FuneralHome 5240 Reisterstown Rd Baltimore, Md 21215 alres 23 . Par I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sinck, or help failure. List only one cause on each line. Approximate Interval Between Onset and Death Non Small UCAR resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕅 No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

<u>ک</u>

Be Completed

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**Funeral** 

Director

28a-f show

Department of Health and Mental Hygiene. Important: yor items 23a or 28a-f show any Injury or other traumatic event, the Medical Exercinal must be notified at

Pages 1 and 2 should be f ment of Health and Mental i ant: If item 27 Is marked or

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner Box 68760,

as the burial-trar

P.0.

Division of Vital Records,

Physician/Medical

δ

Completed

Be

Certification: To

Medical

29b. Signature and title of certifier

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and 24 hours a within 2

				1 🗖 Yes 2 🗆	] No 3 Probably 4 Unknown
				24a. Was an autopsy performed? 1 □ Yes 2 XINo	24b. Were autopsy findings available prior to completion of cause of death?  1 □Yes 2 □No
25. Was case referred to medical examiner?			26. Place of Death	(Check only one)	
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	utpatient 3 DOA	Other: 4 Nursing Hor	ne 5 ☐ Residence 6	Nother (Specify) WSPIQ
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day, Year)	Injury		28d. Describe how injury	
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		arm, street, factory, off	fice	28f. Location (Street and City or Town, State)	Number or Rural Route Number,
29a. Certifier (Check only one)  Certifying Pl 2 Medical Example	nysician: To the best of my knowledgeminer: On the basis of examination are and manner stated.	e, death occurred at t nd/or investigation, in	the time, date and place, my opinion, death occurr	and due to the cause(s) ed at the time, date and	and manner as stated. place, and due to the cause(s)

29c. License number

58303

29d. Date signed (Month, Day, Year)

100

5 State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMAN J CHANGES M) 6701 N. CUNKUS ST TOWSON MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** 2220 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Ba hmore Johns Hopkins Bayview Medica Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3-13-1938 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days Hours Min 1 ☐ M 2 💢 F 71 212-78-6961 N.C. Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Medical Examinar must be notified at Yes 2□No Director MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 72 hours after death with 147 W. Hamburg Street 21230 S Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 ☐No Black Maryland 21215-0036 Specify: ð 3 ₩ Widowed 4 □ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+)
N/A Elementary/Secondary (0-12) llth grade Disabled Disabled and 2 should be filed we ealth and Mental Hygier n 27 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alston Annie Holden Roger ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important; If Item 27 Is n any Injury or other traun once. Baltimore, MD 21217 Reginald Green-Son 1442 N. Mount Street 3altimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 8-7-2009 Mt Carmel Cem Balto, MD 4 ☐ Donation 5 ☐ Other (Specify) March East F/H 22. Name and Address of Facility 21. Signature of Funeral Service Licensee pich 1101 E. North Avenue Balto, MD 21202 nas 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) month **Physician** ena amy bu /Medical Due to (or as a consequence of): Examiner ardiac awy Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off be executed burial-trans and Due to (or as a consequence of) physician a Box 68760, Physician/Medical ed by the attending p detached for use as IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 ☐ Other (specify) P.O. | 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown cate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No certificate 2 No 1 Yes Hospital or Attending Physiclan: '24 hours after death. Funeral Director: After this certificatibly filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar

within 2 To the I

(Check only one)

29b. Signature and title of pertific

31. Date filed (Month, Day, Year)

ollars

tastern

29d. Date signed (Month, Day, Year)

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item\_23a),(Type, Print)

			1 - State Registrar		Cei	tificate of E	Death	Reg	. No.			
3	Physici /Medio		1. Decedent's Name (First, Middle, Last) GOLDIE MYERS					2. Date of Death Month	Day Year	3. Time of Death 12: 25 PM		
	Examir		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or			4c. County of Death			
			Western Maryland H	lospital Cente	r	Hagersto	WII WIIInder 24 Hrs	2 Date of Birth	Washington	Land (Charles on Francisco)		
8,	Funeral Director		123 02 1031	7. Age (In yrs. In	Yrs.	Months Days	Hours Min.	B. Date of Birth (Month, Day, Y) JULY 6, 19!	(ear) Cour 56 VI	RGINIA		
	land w		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation			1	0d. Inside City Limits		
	ith the Marylar or 28a-f show	tor	WV BERKELE	ΞΥ	MARTIN	NSBURG				1 ☐ Yes 2Ã No		
	23e or 28	rai Director	10e. Street and Number 427 DINALI DRIVE			10f. Zip Code 25403		10g	Citizen of What Cour			
980	within 72 hours after deeth with the Maryland ene. then "natural", or Items 23e or 28e-f show ite Madical Examiner must be multied at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1		Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 🕅 No	spanic Origin? (Spec n, Mexican, Puerto R Specify:	ofy Yes or No- ican, etc.)	14. Race - Americ Black, White, Specify:			
21215-0036	ges 1 and 2 should be filed within 72 hours after deeth with the Maryla t of Health and Mental Hygiene. If Item 27 Is marked other then "natural", or Items 23s or 28s-5 show or other traumatic event, the Madical Examinational Permutilial at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired) TAIL SER\	uring most of workin	g 16 (	16b. Kind of Business/Industry GAMING INDUSTRY			
Maryland 2	2 should be filed withir and Mental Hygiene. Is marked other then aumatic event, I to M.	To Be C	17. Father's Name (First, Middle, Last) HENRY DANIEL S	STANLEY			18. Mother's Name	(First, Middle, Ma MARY SMA	,			
	nd 2 should alth and Men 27 is marke r traumatic		19a. Informant's Name/Relationship (Ty, CRYSTAL WELLS/DAUG		City or Town, State, Zip							
Baltimore,	es 1 and of Health f Item 27 r other tr		20a. Method of Disposition  1 ★ Burial 2 □ Cremation 3 □ R		ace of Dispo	sition (Name of matory or other place	Da		c. Location - City or To			
ti m	Pages Iment of I tant: If Ite		4 ☐ Donation 5 ☐ Other (Specify)	FOR		L CEMETERY  . Name and Address	2009		LEX INGTON	, NC		
Ball	permit. Pages 1 and 2 Department of Health 6 Important: If Item 27 Item 27 Item 27 Item 27 Item 27 Item 27 Item 27 Item 27 Item 27 Item 27 Item 27 Item 27 Item 27 Item 27 Item 2005.		21. Signature of Funeral Service License Chaeles M.	WN FUNERAL SBURG, WV	L HOME, PO BO 25402	X 821,						
	Physician /Medical Examiner	ier	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	cations that caused the death re cause on each line.  GLIOBLAS*  Due to (or as a consequence).  Due to (or as a consequence).	TOMP		, such as cardiac or	respiratory arrest	1	Approximate Interval Between Onset and Death		
68760,	ertificate be executed Jing physicien and se as the burial-transit	Medical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	rence of):							
P.O. Box	that the death certifica ted by the attending ph detached for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year		
	ires that signed b I be deta	by	Part II. Other significant conditions cor	ntributing to death but not resu	ilting in the u	nderlying cause give	n in Part I.		cco use contribute to the			
Records,	The law requires that the death c rate has been signed by the attenc page 2 should be detached for us	Completed	LIVER PARASIT					24a. Was an autopsy performe	24b. Were auto prior to co death?	opsy findings available impletion of cause of		
tal		Ö	HERPES ENCEPT 25. Was case referred to medical	HALITIS			26. Place of Death		TNo 1 ☐ Yes	2 No		
of Vital	di S	To B	examiner? 1 ☐ Yes 2 🔀 No	lospital: 1   Inpatient 2   1	ER/Outpatier	t 3 DOA Othe			ce 6 □Other (Specif	(y)		
o u			27. Manner of Death 1. ■Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	?	8d. Describe how	injury occurred			
Division	or Atten ifter deet Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str		'es 2 □ No 2	Bf. Location (Stree City or Town,	et and Number or Rura State)	al Route Number,		
_	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medicai Co	29a. Certifier (Check only one) 1 Certifying Physical Certifying Physical Examination (Check only one)	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death ion and/or in	n occurred at the tim vestigation, in my op	e, date and place, a inion, death occurre	nd due to the caused at the time, date	se(s) and manner as s and place, and due to	stated. o the cause(s)		
	To th withir To th comp	Me	29b. Signature and title of certifier	MD		29c. License	2895		1. Date signed (Month,	Day, Year)		
	2		30. Name and organis of person who co	mpleted cause of death (Item	23а) (Туре,		Pennsylva					

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

AUG 0 4 2009

MYERS GOLDIF

parked

\$2. Registrar's Signature

Hagerstown, MD 21742

09-06042

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Richard McQuaid Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 0050 hrs August 3, 2009 Medical Examiner William McQuaid Richard 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Towson Gilchrist Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (in yrs. last birthday) **Funeral** Foreian Months Davs Hours Country California Director Yrs January 6, 1923 86 554*-*20*-*9221 1 **X**M 2\_\_\_F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10b County 1 Yes 2 X No or 28a-f show Baltimore Parkton Maryland items 23a or 28a-f sho Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menlal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at name injury or other traumatic event, the Medical Examiner must be notified at name. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 21120 United States 1501 Harris Mill Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 1 X Yes 1 Yes 2 X No specify: Specify: White f Yes, Give Year 1943-1946 3 Widowed Divorced 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 5+ Chemist Covernment 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Lasonio William McQuaid 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Jeanne M. Cox/ Daughter 1634 Angus Court, Crofton, maryland August 3. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State Metro Crematory, Inc. 2009 Baltimore, Maryland Donation 5 Other Specify 22. Name and Address of Facility Cremation Society of Maryland, Inc. Signature of Funeral Service Licensee Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure 1 ist only one cause on each line Medical Death COmplications of blunt force neck trauma Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Physician/Medical 23a,PII,27,28a-f,permE, g895 9/22/09 TT AMENDED g physician the burial XUNPENDED certificate be Box 68760. 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 3 Ectopic pregnancy 23b. Was decedent pregnant in the Month Dav Year Live birth Fetal death attending or use as the 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown ned by the a detached fo 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. has been signed to a should be deta ş 1 Yes 2 No 3 Probably 4 V Unknown Hypertensive atherosclerotic cardiovascular disease; Completed 24a. Was an 24b. Were autopsy findings available Chronic obstructive pulmonary disease prior to completion of cause of autopsy performed? 1 🗸 Yes ✓ Yes 2 No 2 No certificate 26 Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certif completely filled in by the funeral director, 25. Was case referred to medical Be Other<sub>4</sub> Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 1 V Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury Certification: 1 Yes 2 X No subject fell Natural Pending 8/3/2009 0050 hrs 2X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1501 Harris Mill Rd or Town, State) 15 28e, Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide residence Parkton, determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 3, 2009 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Russell Alexander MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State U 4 2000 arked Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year ristopher 2:45 PM 2009 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore
If Under 1 Year | If Under 24 Hrs. Baltimore Secours NA 5. Social Security Number 8. Date of Birth (Month, Day, Ye ) 2 - 21 - 6 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Hours 1 X M 2□ Months Days 220-76-6326 44 MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits Randallstown 1 □Yes 2 No Funeral Director MD Baltimore 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with Item 27 is marked other than "natural", or items 23a or other traumatic event, I've Medical Examiner must be a USA 3512 Chapman Road 21133 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or iten Black, White, etcAfrican 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 🛣 No þ If Yes, Give Year or Dates: Specify: American 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Unk. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) NA Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) McFadden Benjamin Mormen Ratha ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3512 Chapman Road Randallstown, MD 21133 Ratha Cooper-Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If It any Injury or o Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08-04-09 Lansdowne, MD Zion Cem. 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licenses MD 21217 638 N. Gilmor Street Baltimore, 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** hypoxia /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificete be executed burial-transi Seizure and Due to (or as a consequence of) signed by the attending physlcian d be detached for use as the buria Physician/Medical yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy certificate perforn 2 No 2 200 1 □Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1X Yes 2 No Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 28d. Describe how injury occurred Natural
Accident within 24 hours after death,

To the Funeral Director: A
completely filled in by the fu death, 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records, P.O. Box 68760,

V

the

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State

Medical

29a. Certifie

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Simmons

04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2000

32 Registrar's Signatura

DHMH 17 Rev 1/2001

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

0066108

29d. Date signed (Month, Day, Year)

			For Amend State Registrar	I <b>tems 24</b>	of Marylar Per	nd / Der Ce	894,08/04 ertificate of	<b>709 this</b> Death	ng Mental Hy	giene Reg. No.	09	24831
	Physicia		1. Decedent's Name (First, Middle 1)	4.0	M	ES A			2. Date of De Month	eath Day	Year	3. Time of Death 0643 AM
	/Medic Examin		4a. Facility Name (If not instituti		number)	AUTE	4b. City, Town, or	r Location of	Death	4c. Cou	inty of Death	h
	Funeral Director		5. Social Security Numberunk	1101	7. Age (In yrs	. last birthda	100001	If Under 2- Hours	Min. 8. Date of Bi (Month, D	av Vear	9. Birti	hplace (State or Foreign untry) unk
	rland ow		Usual Residence of Decedent  10a. State 10b. Count	y	10c. C	ity, Town or	Location					10d. Inside City Limits
	e Mary a-f sh	ctor	MD Bal	imore		Bal:	timore					1 □ Yes 2 □ No
	3a or 28	al Dire	10e. Street and Number 3912 Dorches	ster Road			10f. Zip Code 21	207		10g. Citizen		untry?
92	after death	y Funeral Director	1 Never Married 2 Ma	Armed 1 1 Yes	ecedent Ever in U Forces? s 2 No Give	unk 13	B. Was Decedent of H If Yes, specify Cuba 1 □Yes 2 ☑ No	lispanic Orig an, Mexican, Specify:	in? (Specify Yes or No Puerto Rican, etc.)		Black, White	rican Indian, e, etc. 1ack
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatilt and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it. Modical Eraphia contact in collical an once.	Completed by	(Specify only high	nt's Education est grade complete	ed)	[ (Gi	cedent's Usual Occup ve kind of work done o. DO NOT use retired	during most	of working unk	16b. Kind o	of Business/l	
nd 212	filed withi Il Hyglene. other thar	Be Com	Elementary/Secondary (0-12)  unk  17. Father's Name (First, Middle	unk	e (1-401 5+)		unk	18. Mother	's Name (First, Middle	a, Maiden Surr	name)	unk
Maryland	2 should be and Mental is marked o aumatic eve	To E	19a. Informant's Name/Relation	nship (Type, Print)		19b. Ma	illing Address (Street	and Number	r or Rural Route Numi	ber, City or To	wn, State, 2	Zip Code)
	is 1 and 2 and 2 the alth a item 27 is		Sinai Hospital	-					venue Bal			21215
Baltimore,	Pages 1 annent of He ant: If iten ury or oth		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☑ Other	3 □ Removal fr (Specify) IN S	om State	Place of Dis cemetery, ci	position (Name of rematory or other plac	ce)	Date	20c. Location	on - City or	Town, State
Balt	permit. Pag Department Important: I any injury o once.		21. Signatur Funeral Scrub	/ /// // //				omy Bo	oard 655 W		imore	Street
	Physician	y a	23a. Part 1. Enter the disease, shock, or heart failure. Li Immediate Lause (Final disease or condition	or complications that only one cause of	at caused the dea	ith. Do not	enter the mode of dying	ng, such as d	cardiac or respiratory	arrest,	ee	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	a. Due	to (or as a conse	quence of):	reim					
-	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	DDue	t (or all a conse	quence of):	,					
,8760,	ficate be executed physician and s the burial-transit	dical Exa	resulting in death) Last	Due	to (or as a conse	quence of):						
	rtificat ng phy as the	Medic	IF FEMALE:	U.								
O. Box	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 DL	outcome of pregi ive birth 2☐ Fe regnant at time of nknown	tal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су		23d.	Date of de Month	livery Day Year
rds, P.	quires that t n signed by ild be detac	5	Part II. Other significant condi	tions contributing to	o death but not re	sulting in the	ynderlying cause giv	ven in Part I.	0.0	tobacco use d		o the cause of death?
Division of Vital Records,	The law recate has bee page 2 shoo	Completed			-		Dea	3-0-0	24a. Wa auti per 1 □Yes	opsy formed?	4b. Were au prior to death? 1 ∐ Yes	utopsy findings available completion of cause of
/ita	ician: The certificate ector, pag	Be C	25. Was case referred to medic examiner?	Hospital:			2	oor:	of Death (Check only	one)		
n of	ding Physician: The Ing. After this certificate h funeral director, page	on: To	1 ☐ Yes 2 ☒ No  27. Manner   Ceath 1 ☐ Matural 5 ☐ Pend	28a. D	☐ Inpatient 2 { ate of Injury Month, Day, Year)	28b. Time Injur	e of 28c. Inju	ry at rk?		how injury oc		ecify)
)ivisio	l or Attend after death Director:	Certification: To	3 ☐ Suicide 6 ☐ Coul	mined 200. F	ace of Injury - At uilding, etc. (Spec	home, farm, cify)	M 1 Street, factory, office	]Yes 2□N	28f. Location	(Street and N own, State)	umber or R	ural Route Number,
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	edical Ce		ai Examîner: On t					d place, and due to the			
	To the within To the comple	Me	29b. Signature and title of certif	ier	xi m	D	29c. Licen:	se number	48	29d. Date si	gned (Mont	th, Day, Year)
			30. Name and address of personal L	16 00	el, s	inai I	Hospital o	f Balt	timore			
	Sta Registr		31. Date filed (Month, Day, Yea	4 2009	2. Pegistrar's Sign	A.	park					

#24a+25

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Ivia	,		tificate of				eg. No.	109	24832
	Dhooisi		1. Decedent's Name (First, Middle, La	st)					2	2. Date of Deat	Day	Year	3. Time of Death
	Physicia /Medic		Theodore L.	Meyer						August	1, 20		1:33 P M
	Examin	er	4a. Facility Name (If not institution, give				4b. City, Town, or		n of Death			unty of Death	
_			2602 Clarion Cou		e (In yrs. last	hirthday)	Odent If Under 1 Year		er 24 Hrs. 8	. Date of Birth	Anne Arunde		unde L lace (State or Foreign
	Funeral Director			X M 2□ F	80	Yrs.	Months Days	Hours	s Min.	(Month, Day, Feb 7,	Year) 1929	Mar	yland
	land bw		10a. State 10b. County		10c. City, To	own or Loc	ation					11	0d. Inside City Limits
:	Mary Ff sh	ţċ	Maryland Anne Ar	unde1		00	denton						Magaran Yes 2 No
:	or 28	Director	10e. Street and Number				10f. Zip Code		-	1	0g. Citizen	of What Coun	itry?
,	23a	ral	2602 Clarion Cou	1			<u> </u>	113_			-	ited S	
	er deg	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?		13. W	as Decedent of H Yes, specify Cuba	lispanic an, Mexic	Origin? (Speci can, Puerto Ri	ify Yes or No- can, etc.)		Race - Americ Black, White, e	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinar must be rediffed at once.	ğ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1√TYes 2∐N IfYes, Give Year or Dates:	10	1	□Yes 2X No	Speci	ify:		Spe	ecify: W	hite
2-0	72 ho	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16	6a. Deced	ent's Usual Occup kind of work done O NOT use retired	ation during m	ost of working		16b. Kind o	of Business/Ind	dustry
12	ithin in han "	mpl	Elementary/Secondary (0-12)	College (1-4or 5	+)		ONOT use retired tion Age			-	R	Railroa	đ
5	iled w Hygie ther t	ပ္သို	17. Father's Name (First, Middle, Last	)		Sta	CION Age		ther's Name (	First, Middle, M			<u>u</u>
an	d be f antal ced o	To Be	George Wolthe						Tosa	ephine	Strna	d	
ary.	shoul ind M i marl umati	F	19a. Informant's Name/Relationship	4	11	9b. Mailing	g Address (Street	and Nur					Code)
Š	and 2 alth a 1 27 is er tra		Agnes Helen Meyer	/wife	2	2602	Clarion	Cour	t #104	0dent	on, M	iary1an	d 21113
ore	es 1 a of He of He fitem		20a. Method of Disposition  1X Burial 2 □ Cremation 3 □	Removel from State	20b. Place ceme	e of Dispos etery, crem	sition (Name of atory or other plac	ce)	Dat	te	20c. Location	on - City or To	wn, State
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Baltimore, Maryland	permit Depar Impor any in		21. Signature of Funeral Service Lice	$\Omega$		Do:	Name and Addre	ss of Fac Fune	ra1 Ho	me & Cr	emato	ory, P.	A.
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			23a. Part Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	ne.	0.				,			Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	a. Due to (or as	a consequence	ce of):	Myclon				_	<del></del>	10 gan
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68	tificat g phy as the	ledic		u	,								
ŏ	th cer tendin r use		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1  Live birth			Ectopic pregnanc	cv			23d.	. Date of delive	
P.O. Box	Physician: The law requires that the death ce this certificate has been signed by the attendiral director, page 2 should be detached for use	Physician/	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant a 9 ☐ Unknown			Other (specify) _					Month	Day Year
<u>o.</u>	that the		Part II. Other significant conditions	contributing to death b	ut not resultin	g in the un	derlying cause giv	ven in Pa	rt I.	23e. Did to	bacco use	contribute to the	he cause of death?
Division of Vital Records,	n sign	d by								1 □ Ye	es 2 🗆 N	lo 3□ Prol	bably 4 Unknown
000	aw rec is bee 2 shou	Completed								24a. Was a		4b. Were auto	psy findings available
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UC .	Jing F	ion	27. Manner of Death  11 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y, Year)	b. Time of Injury	28c. Inju Wor M 1 □	ry at rk? ]Yes 2		3d. Describe he	ow injury oc	ccurred	
<u>is</u>	Attending ir death. ector: After by the funer	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	00 Place of Ini	ury - At home	, farm, stre		1165 2		3f. Location (S	treet and N	lumber or Run	al Route Number,
Ö.	al or / s after al Dire	Certification: To	4 ☐ Homicide determined	building, et	c. (Specify)				V	City or Tow	n, State)		
,	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. Within 24 hours after death, this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	Medical (	29a. Certifier (Check only one) 1 Certifying P	hysician: To the best miner: On the basis of and manner sta	f examination	dge, death and/or inv	occurred at the treatment occurred at the treatment of the treatment of the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred at the treatment occurred a	ime, date opinion,	e and place, a death occurre	nd due to the o	cause(s) an date and pla	nd manner as s ace, and due t	stated. o the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	1			29c. Licens	se numb	er			igned (Month,	Day, Year)
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	84,		30. Name and address of person who	55 80	wth	Green	e 87	Bo	alhim	ar t	10	212	0 (
	Sta Registi		31. Date filed (Month, Day, Year) - AUG 0 4 2	009 She	ar's Signature	1	are						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician**  $a^{\,M}$ HOLLIE MIRIAM MLYNARCZYK 2009 4:30 August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Hospice Care Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 🗆 M 128-36-0669 Feb. 21, 1945 64 New York Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examine mass 200. 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location 1 ☐ Yes 2 ☐ No Director MD Howard Jessup 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8038 Red Jacket Way 20794 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 **X X**o 14. Race - American Indian. Black, White, etc. 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2XXXo Specify. ò Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Community Elementary/Secondary (0-12) College (1-4or 5+) 1 year Customer Service Service Association 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gerald Godfrey Helen Brown ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael G. Mlynarczyk / spouse 8038 Red Jacket Way Jessup, Maryland 20794 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🏋 remation 3 ☐ Removal from State West Arundel Crematory 8/4/2009 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service bicensee Bonard Address of Facility al Home, P.A. / M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part 1. Enter the disease, shock, or heart failure. Li complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cast cano disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 1 No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a I be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>გ</u> 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a. Was an autopsy performed? 1 □ Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of De th 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. the tyle of certifier 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 31. Date filed (Month, State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

AMEND ITEM# 17,18,20a-c,22,peiffh, 394,875,09, 85

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2009 Month **Physician** July 24, 9:43 AM M Kenneth Wayne Miller /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1132 Falls Hill Drive D4 Baltimore Baltimore | If Under 1 Year | II Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept 25, 19 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** 1**⊠**M 2□F Yrs Director 213-44-9066 1944 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "naturel", or Items 23a or 28e-f ehow any Injury or other treumetic event, the Madical Examiner must be notified at once. 10b. County MD Baltimore Baltimore City ty Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 USA 1132 Fallshill Drive #D4 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: unk 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2€ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White δ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 1aboror construction 17. Father's Name (First, Middle, Last) \_\_\_\_\_\_ 18. Mother's Name (First, Middle, Maiden Surname) \_\_unk\_ Donald Norris Miller Anna Elizabeth Parks ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rith Margaret Miller/spouse 1132 Fallshill Drive #D4; Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crem.

Aug. 4, 2009

Beltsville, MD

22. Name and Address of Facility CAFA Stephen D. Lohrmann P.A.

8717. Green Pastures Dr. 10 Baltimore, MD 21286

23a. Partl Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximate disease or condition resulting in death)

Aug. 4, 2009

Beltsville, MD

21286 20a. Method of Disposition 20c. Location - City or Town, State Approximate Interval Between Onset and Death **Physician** ay 8 /Medical Due to for as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner has been signed by the attending physicien and ge 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 1 🗌 Yes 2 🗆 No 4 Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? res 22 No After this certificete 1 Yes To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifice filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Registrar DHMH 17 Rev 1/2001

State

11

29a. Certifier

(Check only one) 29b. Signature

31. Date liled (Month, Day, Year)

Medical

Road

seocye Honnowi

32. Registrar's Signature

3730 Falls

30. Name and address of person who completed cause of death (Item 23a) (Type Print)

seorge Hennawi, MD

AUG U 4 2009

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Chandra Kala Misra 02, 2009 8:30 A August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🗓 F Director 220-84-6924 75 05-08-1934 India Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 XNo Montgomery Germantown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10 items 23a 13501 Jamieson Place 20874 Funeral United States 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married ,0 1 ☐ Yes 2 🛣 No ģ Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be . Pages 1 and 2 should be fill trnent of Health and Mental Hiant: If item 27 Is marked oth Brijrani Devi Misra injury or other traumatic ပ Ram Kishore Misra 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 Is any injury or other trau 13501 Jamieson Place Germantown, Maryland 20874 Dwarika Nath Misra / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory | 08-05-2009 Odenton, Maryland 21. Signature of Funeral Service License P. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road Odenton, Maryland 21113 Agril Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Bronchiolitis Obliterans Years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and use as the burial-transi 2 Weeks Acute Myocardial Infarction that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Pulmonary Fibrosis IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Recent Left Knee Replacement ( 07/20/2009 ) 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 □ No Type 2 Diabetes Mellitus, Renal Insufficiency 24a. Was an in by the funeral director, page 2 autopsy performe 2 12 No 1 □ Ye*s* 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Maryland 21215-0036

Baltimore,

Box 68760,

P.0.

Division of Vital Records,

State Registrar

Barbara Supanich RSM, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sever B. Jako

Suparich Roy up

D 0065485

1500 Forest Glen Road Silver Spring, Maryland 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 5:40 AM MEAGHER PHILIP 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE. BON SECOUNS MD HOSPITAL Baltimore | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | Months | Days | Hours | Min. | March | 31 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. March 1 № M 2 □ F Maryland 217-64-3918 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, it e Nexical Examiner must be notified at 10d. Inside City Limits 10c. City. Town or Location 10a State 10h Count 1 ☐ Yes 21X No Director Odenton MD Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21113 USA 556 Stone Hill Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: 1 ☐ Yes 21 No Specify: white ð 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katherine Annette Lurz Joseph Thomas Meagher ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trauonce. Michael Meagher/brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4K Donation 5 ☐ Other (Specify) Signature Funds Sice Licensee Ronald S. Warde 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Mector Baltimore, Maryland 21201

23a. Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cuse (Final disease or contion resulting in death) Physician SEPSIS /Medical Due to (or as a consequence of): Examiner PNEUMDNIA Sequentially list conditions, and all cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician at the burial Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ PARKINSONS 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed has been PIRATURY FAILWILE UENTI LATOR 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy DEFENDENT ; SEIZHRE ATRIAL FIBRILATION certificate 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation n 24 hours after death.

e Funeral Director: Aft
bletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 ho

To the Fune

completely f (Check only and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

Registrar

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32. Registrar's Signature

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30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Alig U 4 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ATEM 9 per FH, 6894,8/4/09, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 10:28 PM Mc Nair 200 arence 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Memoria Baltinore Year If Under 24 Hrs. 8. Date of Birth (Month, Day 9. Birthplace (State or Foreign Country) SC WAKHOWA f Under 7. Age (In vrs. last birthday Months Days (Month, Day 10 14 Hours Min 1**™** M 2□ F Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1XYes 2□No Baltimore  $M_0$ 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2/2/17 USA 301 Mr. Mecher 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 Mayes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify: Black 3 ₩ Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Glive kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 200K 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname unknown unKnòwn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 2/218 Bernice Jennings *triena* 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - Oity or Town, State Date 20a. Method of Disposition Garrism 1 Burial 2 ☐ Cremation 3 ☐ Removal from State HOMES 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Eugen Lervin Licensee 00 NO 155 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ar Pa Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 0 24a. Was an autopsy performed Hypertensis 25. Was ase referred to medical examiner? 1 ☐Yes 2 ☐ No 2 X No 1 Yes 100 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of De th 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

/Medical Examiner that the death certificate be executed Box 68760. Ö Records, Division of Vital

physician attending phase as the detached signed to page 2 should peen certificate funeral director, this After Hospital or Attending n 24 hours after death.

e Funeral Director: A pletely filled in by the fu death. completely within 2

**Physician** 

/Medical

Examiner

Director

Funeral

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Certification: To

Medical

(Check only one)

30. Name and address

29b. Signature and title of certifier

**Funeral** 

Director

d other than "natural", or Items 23a or 28a-f show event, the Medical Examirar must be nutified at

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any lightly or other traumatic event any figury or other traumatic event once.

**Physician** 

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death with the Maryland

filed within 72 hours after

Maryland 21215-0036

Baltimore.

State Registra

and manner stated

of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 1:30 P M 2009 AUG. JOSEPHINE CAMINO McMULLIN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HARFORD 406 CEDAR SPRINGS ROAD BEL AIR If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months Days Hours Min. 1 □ M 2 🗓 F Director 94 June 2, 1915 Pennsylvania 209-09-9348 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland | Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 406 Cedar Springs Road 21015 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify Specify. à 3 ₩idowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be should be Filomena (nmn) Camino Anthony Joseph Camino ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Department of Health Important: If item 27 any injury or other troone. Air, MD 21015 406 Cedar Springs Rd., Bel Patricia Miltenberger / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jefferson Memorial Park 8-5-09 \_ Pittsburgh, PA 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Lie 1317 Cokesbury Road, Abingdon, MD 21009 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) 0 /Medical Due to (or as a sequence of) Examiner Draw Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed that initiated events burial-tra resulting in death) Last Due to (or as a consequence of): physician the burial Box 68760. Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) signed by the a Ö 9 ☐ Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, <u>Ş</u> 2 No 3 Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 **X** No 1 ☐ Yes 2 Z No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1∐Yes 2 No Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division To the Hospital or Attending 1'Natural 5 ☐ Pending investigation 1 □Yes 2 □No death. Director: 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M 020 31. Date filed (Month, Day, Year) 32. Registrar's S State AUG 0 4 2009 Registrar

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 JULY 31 1:10 A MAKAROVSKY SHULIM 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death HOWARD COLUMBIA 7080 CRADLEROCK WAY, #911 | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 03/20/1928 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) UKRAINE 81 217-33-6762 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No HOWARD COLUMBIA 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 21045 USA 7080 CRADLEROCK WAY, #911 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 1 □Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify: WHITE 3 ¥ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) MECHANICAL ENGINEER GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **EFRAIM** MAKAROVSKY MALKA MAKAROVSKAYA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 352 BONNIE MEADOW CIR., REISTERSTOWN, MD DAUGHTER VALENTINA TARKOVSKY / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State COLUMBIA MEMORIAL PARKO8/02/2009 COLUMBIA, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS. . INC. Signature o Funeral Service Lice 21208 8900 REISTERSTOWN RD., PIKESVILLE, MD Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Brea J-1 5 disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 □Yes

**Physician** /Medical Examiner

permit. Pages 1 and 2 s Department of Health ar important: If item 27 is any injury or other trau once.

**Physician** 

/Medical

10a. State

MD

Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f show

Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hyglene. ant: If item 21 is marked other than "natural", or items 23a or ant: If item 21 is marked other than "natural", or items 13a or other traumatic event, the Marica Entrine mast be a uny or other traumatic event, the Marica Entrine mast be a

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records, P.O.

**Funeral Director** 

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the Maryland

Examiner attending physician and for use as the burial-transi certificate has been signed by the rector, page 2 should be detached : After this certific funeral director,

Physician/Medical چ Be Completed Certification: To

25. Was case referred to medical examiner?

Medical

Hospital or Attending Physician: The law requires that the death certificate be executed death. after death | Director: / d in by the f 24 hours after e Funeral Dire letely filled in b сотріетел

the within 2 To the I

> State Registrar

DHMH 17 Rev 1/2001

27. Manner of Death Natural 5 ☐ Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

1 Yes 2 No

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Date of Injury (Month, Day, Year)

and manner stated

28b. Time of

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

meat filed (Month, Day, Year)

AIIG 0 4 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 28 3:00 PM 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3550-0 Anne Arunde Burr If Under 1 Year | If Under 24 Hrs. | Hours | Min. Meade Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Funeral 1 M 2 F 137-48-6268 53 9-6-New Jersey Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experience must be notified at 1 Yes 2 No Director Fort Meade MD Anne Arundel within 72 hours after death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3550-C Burr Court 20755 **USA** Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Wes 2 ☐ No 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2√€ No Yes Give Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Amıy Telecon Analyst Government 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) Be Lillie Mae Clayborne Odessie Carter ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1406 Bristol Station Court Carteret, NJ 07008 Monique Carter/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ardent Cremation Services 08/04/2009 |Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ardent Cremation Services 7522 Connelley Drive, Ste.N, Hanover, MD 21076 21. Signature of Funeral Service Licenses Laura C. Hardesty M01197 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ancreatic Recurrent Metastatic **Physician** Cancel disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Recurrent Peritoneal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-trar Due to (or as a consequence of) Dívision of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes been si should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 22No this certificate 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No Hospital: 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) 1 Inpatient Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 5 Pending investigation 1 Natural in 24 hours and war the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s). Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 0 29b. Signature and title of certifier VA 0101237228 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patel, 6900 Georgia Ave, NW MD

State Registrar

D.

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

**ORIGINAL** 

32. Ragistrar's Signature

Ceneura

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #1, perMD 9894 8/4/09 TT State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) Robert Darin Owens, Sr 2. Date of Death **Physician** 3000 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ALTIA NN. MAR Social Security Number EDICAL Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day) **Funeral** Days Hours 1 🔀 M 2 🗆 F Mary land 9, 1965 Apr. Director 217-74-9746 Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hjury or other traumatic event, the Medical Exprinter nast be notified at once. 1 ☐ Yes 2 No Director Maryland Harford Joppa 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21085 118 Breakwater Ct. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Year or Dates: altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. <u>۾</u> 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Tile & Marble Elementary/Secondary (0-12) College (1-4or 5+) Installation Owner/Operator 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be June Mildred Reddish William Robert Owens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1719 Pine Forest Ct., Bel Air, Maryland 21014 June M. Owens / Mother Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 8/3/2009 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 22. Name and Address of Facility

McComas Funeral Home, P.A. of Funeral Service Licensee 1317 Cokesbury Road, Abingdon, MD 21009 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death, shock, or head failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) ORONAF **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical Hospital or Attending Physician: The law requires that the death certificate IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Division of Vital Records, P.O. cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 1 ☐Yes 2 ☑No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 1 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death.

i Director: Af d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hour 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe S. GREENE ST. BAL 31. Date filed (Month, Day,

Registrar DHMH 17 Rev 1/2001

State

			For	State of Maryland / D		and Mer	ntal Hygiene	2009	24842
			<ul> <li>State Registrar</li> <li>Decedent's Name (First, Middle, Last)</li> </ul>		Certificate of Death	2.	Reg. No Date of Death	2000	3. Time of Death
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	Funeral			7. Age (In yrs. last birth		24 Hrs. 8. Min.	Date of Birth (Month, Day, Year)	9. Birthp	place (State or Foreign try)
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4	ems 23	Funeral	11. Marital Status	Was Decedent Ever in U.S.     Armed Forces?	13. Was Decedent of Hispanic Ori	igin? (Specify	Yes or No-	14. Race - Americ Black, White,	
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Dai	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensed	L. Russ	Joseph L. Rus	s Fun	eral Hor	ne PA.	1216
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	<b>5.≱ 6</b> 8	27)	1 din	mp	RES-	000		LY 30	
			30. Name and address of person who co						re, MD, 21287
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature					
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ORIGINAL

DHMH 17 Rev 1/2001

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Вох	eath certific attending pl for use as t	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pro		3 ☐ Ectopic <sub>I</sub>	rognanov			23d. Date	of delive	
O. B	Attending Physician: The law requires that the death certificate be executed refeath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at time 9 ☐ Unknown		5 ☐ Other (s				Mont	:h	Day Year
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Division of Vital Records,	or Atten after deat Director: in by the	Certification: To	2 Accident Investigation 3 Suicide 6 Could not to 4 Homicide determined	oe 290 Place of Injury	At home, farr pecify)				28f. Location (Str City or Town,		r or Rura	l Route Number,
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral director.	Medical Ce		hysician: To the best of my iminer: On the basis of exa and manner stated.								
	To the within Fo the youngle	Mec	29b. Signature and title of certifier	O C		29	c. License nun	nber	29	d. Date signed	(Month,	Day, Year)
	. 20		Mark Hos	nell	MD		0005	8082	_	7/29	1/0	9
			30. Name and address of person who	completed cause of death	(Item 23a) (7	ype, Print)	00	· A	-	100	/a A	212-11
841			Mark Gosh &	32. Registrar's S	N-(h	arles.	JT JUI	TC 550	10U	Ison A	10	21204
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TTEM# 2015, per Fn, G894,8 F/709, wS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 1:50рт м 31, July Marian Porter /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Manor Care Nursing Catonsville Home Baltimore 7. Age (In yrs. last birthday)
74 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 ☒ F Director 218-30-6099 10-18-MDUsual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show ital Hygiene. Id other than "natural", or Items 23a or 28a-f shov event, the Medical Expressor mast by notified at ¶Yes 2□No Director MD NA Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2712 21225 Bookert Drive USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "naturar", or Items 23s any injury or other traumatic event, Its Wedforl Expriser, is used any injury or other traumatic event, Its Wedforl Expriser, is used once. 12. Was Decedent Ever in U.S.
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1 ☐ Yes 2 ☐ Yoo
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. African 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 No ੬ 3 Widowed 4 Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Security Admin Clerk 12 th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Williams Bertha ဂ္ White 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Williams-Son 2712 Bookert Drive Baltimore, MD 21225 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Meneter 7 1 control (Name of Place) 1 △ Burial 2 ☐ Cremation 3 ☐ Removal from State 08-05-09 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home P.A. 21. Signature of Funeral Service Licens 22. Name and Address of Facility 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EREBRO VASCULAR Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to lor as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖼 No Month Day 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown s been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CARDIOVASCULAR 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has funeral director, page 2 t autopsy performed? Yes 2 200 1 □Yes 1 ☐Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. 28d. Describe how injury occurred 1 Natural Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0059107 M. D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REISTERSTOWN MD 21136 GENTER. UMA BUSINESS DRIVE 324 Registrar's Signature 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

Registrar

Receive

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JULY **Physician** 11:10 A M 2009 DAN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HOSPITAL TIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 🗹 F 220-38-9548 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Mydical Examination and once. 1 Pres 2 □ No Director timure MD 10g. Citizen of What Country? 10e. Street and Number 820 S USA 21229 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. 11. Marital Status Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. ≥ 3 ₩idowed 4 ☐ Divorced 10/ack Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Dir. of DAyCare 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be Henry Loc Kley ဥ 19b. Mailing Address (Street and Number o Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. rint) Mary Margret Brown 20a. Method of Disposition Uto. MI) 21207 Friend 4301 Eth Land 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State on Forest 8-5-09 Quings Mills MD
22. Name and Address of Facility aughn C. Green Fine Kils Errics 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Buto. MD21209 Pike Immediate Cause (Final disease or condition resulting in death) ASPIRATIO, Physician Mo /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of) Examiner sician and burial-transit Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by OVARTAM 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

Division of Vital Records, P.O. Box 68760,

altimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should I

P

29b. Signature and title of certifier ind

(Check only one)

MID

and manner stated.

29c. License number P22253 29d. Date signed (Month, Day, Year) 30 2009.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAMICHHANE, DIMAN 900 S. CATON AV, BALTIMORE

Registrar

# Baltimore. Maryland 21215-0036

Division of Vital Records. P.O. Box 68760.

		For State	ype or Print in E State of Marylan	d / Depa		lealth and N	Mental Hygie	_	21.81.6
Physic /Med		1. Decedent's Name (First, Middle, Last)  Do		Parrot			2. Date of Death Month July 23,	Day Year 2009	3. Time of Death 8:15
Exam Funera Directo	iner	4a. Facility Name (If not institution, give states and states and states and states are states and states are states and states are states and states are states and states are states are states and states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are states are	e.	last birthday) Yrs.	4b. City, Town, or Salis If Under 1 Year Months Days		8. Date of Birth (Month, Day, Oct 19,	4c. County of Deat Wicomi 9. Birt 1948	
		Usual Residence of Decedent  10a. State 10b. County  Maryland Wicomic	10c. Cit	y, Town or Lo lisbur	У				10d. Inside City Limits 1 ☐ Yes 2 <b>X</b> No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Mcdical Eventinal parallels and any injury or other traumatic event, I'm Mcdical Eventinal bandliked at	Funeral Director	10e. Street and Number 425 Patterson Av  11. Marital Status unk 1 Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces? unk 1 □Yes 2 □ No		10f. Zip Code 21804 Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto		g. Citizen of What Co USA 14. Race - Ame Black, Whit	erican Indian,
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Physiciar /Medica	ı	23a. Par 1. Enter the distance, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the deather cause on each line.  a	As	CUD	ig, such as cardiac	or respiratory arres	SI,	Interval Between Onset and Death
cate be executed physician and the burial-transit	dical Examiner		Due to (or as a consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of t						
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e law requires that the de has been signed by the	ē	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	1 ☐ Yes	s 2 No 3 F	
ian: The law rtificate has to, page 2 s	e Completed	25. Was case referred to medical				26. Place of Dea	24a. Was an autopsy perform 1 Tyes 2	ed? prior to death?  YNo 1 □ Ye	utopsy findings available completion of cause of
To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ation: To B	examiner? 100 Yes 2 No  27. Manner of Death 100 Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day, Year)	ER/Outpatie 28b. Time of Injury	of 28c. Injur Wor	y at	ome 5 Resider 28d. Describe how	nce 6 Other (Spewinjury occurred	ecity)
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To the Hos within 24 hd To the Fun completely	Medical		iner: On the basis of examinand manner stated.	ation and/or ir	nvestigation, in my o	opinion, death occu	urred at the time, da	ite and place, and du	e to the cause(s)
		30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type,	Print) E. Carrol	1 54.	Salishy	ws z.s	301
S Regis	tate strar	31. Date filed (Month, Day, Year)  AUG 0 4 2009	32. Registrar's Sign	par	les .				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 3<sup>Day</sup> 200gar **Physician** 1:56 AM August, Josephine Pilone /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** St. Agnes Hospital Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 M 2 X F Director 220-14-5563 May 29, 1926 Maryland 83 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, Its. Andion Examiner must be notified at 10a. State 10b. County 1 ☐ Yes 2X No Director Baltimore Maryland 10e. Street and Number Baltimore 10g. Citizen of What Country? 10f. Zip Code Be Completed by Funeral United States 21224 7616 Gough Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☑ No If Yes, Give<sup>4</sup> Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: White 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 6 years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernesta Pergola Francisco Cammarata ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a
Department of Health an
Important: If item 27 is
any injury or other trauonce. Baltimore, Md. 21223 1911 W. Lombard St. Gerard Pilone 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 8/7/2009 Baltimore, Maryland Oak Lawn Cemetery 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licensee Dundalk, Maryland 21222 7922 Wise Avenue Part 1. Enter the disease of complications that caused the shock, or heart failure List only one cause on each line Approximate Interval Between Opset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Luw /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as sequence of) or Attending Physician: The law requires that the death certificate be executed after death. Box 68760% Due to (or as a consequence of) Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗆 No 1 🗆 Yes 1 ☐ Yes 2 00 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 \sum Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 🗆 No investigation the Director: 6 ☐ Could not be determined 3 🗌 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a

To the Funeral C Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29d. Date signed (Mopth, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Pritchett Gilbert Lamar 12:15 PM 30, 2009 July 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Fort Howard Baltimore Co. 7505 Oak Avenue If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday Days Hours 1 XM 2 ☐ F 80 19,1928 212-26-7868 Maryland Aug. Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ANo Fort Howard Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21052 United States 7505 Oak Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 √yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Yes. Give Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: WWII 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Metallurgical Tester 11 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary A. Wilson Claude Pritchett 19a. Informant's Name/Relationship (Type. Print) Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Eleanor Jean Pritchett 21052 7505 Oak Avenue Ft. Howard, Maryland 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 8/4/2009 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee <sup>22</sup> Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Approximate Interval Between Onset and Death part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 3 month Due to (or as a consequence of) Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant

**Physician** /Medical **Examiner** 

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Important: If ite
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**Physician** 

/Medical

**Examiner** 

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**Funeral** 

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

ed other than "natural", or items 23a or 28a-f si event, the Medical Eva ..it at purst be notified

Sician and burial-trans attending physician for use as the buria sign page 2 certificate this

The law requires that the death certificate be executed

or Attending Physician;

To the Hospital

death.

Division of Vital Records, P.O. Box 68760

Examiner Physician/Medical ģ Completed Certification: To Be ours after death.
neral Director: / within 24 hours a Medical completely

in the past 12 months? 1 □Yes 2 □No 9 □ Unknown		er (specify)		Month Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the underly	ying cause given in Part I.	23e. Did tobacco us	se contribute to the cause of death?  No 3 Probably 4 Unknown
			24a. Was an autopsy performed 1  □Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical		26. Place of De	ath (Check only one)	
examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	☐ DOA Other: 4 ☐ Nursing	Home 5 Residence 6	Other (Specify)
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		28c. Injury at Work?  1 □ Yes 2 □ No	28d. Describe how injury	occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, f building, etc. (Specify)	actory, office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,
	ysician: To the best of my knowledge, death occ niner: On the basis of examination and/or investi- and manner stated.			
29b. Signature and title of certifier	latefult ho	29c. License number	29d. Date	e signed (Month, Day, Year)
30. Name and address of person who  William C. Water Si	complete cause of death (Item 23a) (Type, Print	are Drive Se.	NOU Baltin	Lore, MD a 1237

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State Registrar

31. Date filed (Month, Day, Year,

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #26 per MD g894 8/4/09 TT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Month August 2, Catherine Marie Parsons 3:50 A.M. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Tate House Linthicum Anne Arundel 8. Date of Birth (Month, Day, Year) 10/27/1969 Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs 6. Sex 7. Age (In vrs. last birthday) Min. Months Days Hours 1 □ M 2 🔼 F 217-64-6601 39 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 Yes 2 No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2134 Chantilla Road 21228 United States 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 25 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Administrative Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ronald G. Parsons Adelina Battaqlia 19a. Informant's Name/Relationship (Type. Print)
Adelina Parsons / Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2134 Chantilla Road Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral 08/06/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility David J. Weber Funeral Homes, PA 21. Signature of Funeral Service Lice 5311 Edmondson Avenue Baltimore, Maryland 21229 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC Year disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner?

**Physician** /Medical Examiner

burial-transit

the attending physician ned for use as the burial

certificate

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Hospital

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within 24 hours a er deatl To the Funeral Director:

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Certification: To

Medical

Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

**Physician** 

**Examiner** 

**Funeral** 

**Director** 

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items 23a

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permit. Pages Department of Important: If it any Injury or c

Pages 1 and 2 should

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Completed

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or other traumatic event, the Medical Examiner must be notified at

be filed within 72 hours after

altimore, Maryland 21215-0036

/Medical

2

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Examiner Physician/Medical IF FEMALE: 9 Unknow \$ Completed

1 Tes 2 No

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day, Year)

and manner stated.

26. Place of Death (Check only one) Other: 4 Nursing Home Thesidence 6 HOther (Specify) Hospice 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

MD

32. Registrar's Signature

28b. Time of Injury

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier

AUG 0 4 2009

31. Date filed (Month, Day, Year)

5 Pending

investigation

6 Could not be determined

29c. License number D16354

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CATON ANE BALTIMORE MO 900

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#19a.perINF, G894,874709, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 10450n Month **Physician** 10110 V9 (YW)9 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Director 212-84-1271 47 21 MD Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 XYes 2 □ No Director other traumatic event, the Medical Examiner must be notified Baltimore MDNA 10e. Street and Number 10g. Citizen of What Country? ö items 23a 21231 U.S.A. Funeral 243 Douglass Court Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after Never Married 2 Married 1 Yes No If Yes, Give Year or Dates: ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ Specify: 3 Widowed 4 Divorced Black "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) is marked other than College (1-4 or 5+) Cashier Gas Station 2th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lemuel Garfield Hazel Harrell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brother it of Health 1878 Cedar Grove Road, Conley, GA 30288 Lemuel Jason Rouson II-Son permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date XXBurial 2 Cremation 3 Removal from State ☐ Donation 5 ☐ Other (Specify) King Memorial Park 8/7/09 Woodlawn, Md Signan Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Md 21215 r/1. Enter the disease, or complications that caused the ock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death OFSIS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Yes 2 No Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Z No 1/ inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 🗌 No completely filled in by the within 24 hours after deat To the Funeral Director: Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 29a, Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 29, 2009 Res - 000 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Asnie Helgeson 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 4 2 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician 0245 2009 Lynessa August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A**Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1 🗆 M 2 🔀 F 2009 Maryland 212-85-4087 4 Apr. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 Yes 2 No Director Baltimore Towson Maryland 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 21284 USA 47 Acorn Circle Apt. 204 by Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Specify: Black filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education the Medical (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) other than Infant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 Health and Menta em 27 is marked Amri Kibunja Jaslee Rouson other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 47 Acorn Circle Apt.204 Towson, MD 21286 Jaslee Rouson/ Father 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of 20a. Method of Disposition permit. Pages 1
Department of I
Important: If ite
any injury or ot
once. 1 Burial 2 Cremation 3 Removal from State Mt. Zion Cemetery 8/4/09 Lansdowne, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home Libensee 21. Signature 1 Funeral Service 5240 Reisterstown Rd Baltimore, MD 21215 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between 23a. Pad shock, or beart failure. List only one cause on each line. Immediate C se (Final Rhabdoid Tumor of Tratoid Physician Atypical disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for an a consequence of or Attending Physiclan; The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical nding puse as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Live birth Month Dav in the past 12 months? Pregnant at time of death 5 Other (specify) d by the at 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4  $\square$  Nursing Home 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 1 Inpatient 5 Residence မ this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manner of Death Certification: (Month, Day Year) Injury Director: After 5 Pending investigation 1 Natural 1 🗌 Yes 2 🗌 No 2 Accident filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled hours To the Hospital l 🗹 Certifylng Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 - Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0060731 August 1 2009

Registrar

State

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jason

AUG 0 4 2009

31. Date filed (Month, Day, Year)

far. rus

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 16b per fh g894 8-4-09 vt State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Rollins 1:25 PM Faith 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner NA Baltimore Sama 7. Age (In yrs. last birthday) ritan If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01-08-44 9. Birthplace (State or Foreign Social Security Number **Funeral** Days Hours Country MD 1 □ M 2 📈 F 219-40-6141 65 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ms 23a or 28a-f show must be notified at XXYes 2 □ No NA Baltimore Directo MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21239 USA 1721 Hartsdale Road or items 23a Funeral 14. Race - American Indian, Black, White, etcAfrican 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hygiene. 1 Never Married 2 Married 1 □ Yes 2 No Specify Specify: American Completed by 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Admiti (Give kind of work done during most of working life. DO NOT use retired) Services Security Elementary/Secondary (0-12) College (1-4or 5+) Social Clerk land 2 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida King Raymond Collins ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1721 Hartsdale Road Baltimore, MD 21239 Horace L. Rollins-Husband Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 14 Burial 2 □ Cremation 3 □ Removal from State 08-11-09 Owings Mills, 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Wylie Funeral Home P.A. 22. Name and Address of Facility 21. Signature of Funeral Service License Gilmor Street Baltimore, MD 21217 638 Ν. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Small cell **Physician** non /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown After this certificate has been signed by tuneral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 DER/Outpatie⊓t 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Good Samari Jan

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day,

Registrar's Signature

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5601 Loch Raven

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Baltimore,	pernit. Page Department o Importent: If any injury or		4 Donation 5 Tother Specification of Funeral Septica Licer Ronald S	win state/		22. Name and State A Baltimo				. Balt	imore	Street	Ė ,,
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	ath certificate attending phy: for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1   Live birth 2   Fet	el déath	3 Ectopic pre	gnancy	e Cu	t'ou		d. Date of delik	Yery Day	Year
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Records,	aw require s been sig 2 should be	Completed b							1 ☐ 24a. Was		No 3 ☐ Pro		
r	The ate h page	Be Com	25. Was case referred to medical examiner?				26	i. Place of Dea	auto perfi 1 ☐ Yes	2 No	prior to co death? 1 ☐ Yes		cause of
5	ding Phy I. After this funeral d	၉	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		ER/Outpa 28b. Time Injur		c. Injury at Work?	4 ☐ Nursing H	ome 5 ☐ Res 28d. Describe	idence 6 8 how injury o	Tother (Speci occurred	N ALI	
	- 2 2 2	Certification;	3 Suicide 6 Could not be determined	building, etc. (Speci	fy) 				City or To	wn, State)	Number or Run		mber,
	To the Hospital or within 24 hours aft To the Funeral Dis completely filled in	Medicai	one)	ysician: To the best of my knoning: On the basis of examination and manner stated.	owledge, de ation and/or	r investigation, i	n my opinio	on, death occu	and due to the red at the time	date and pl	lace, and due t	to the cause(	
	To To con	-	29b. Signature and title of certifier	do ans			327				signed (Month,		
			30. Name and address of person who FERMIN & A 31. Date filed (Month, Day, Year)	completed cause of death (Iter	m 23a) (Typ	pe, Print) 7	1NT	かんり	MA	81	210	80	
	Sta Registr	10	31. Date filed (Month, Day, Year)  AUG U 4 20	/.	Ø. 4	barker							

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	aryland /		rtment <i>tificate</i>			and M	-	gien Reg. N	-211	09	24	854
	Physici	an	1. Decedent's Name (First, Middle, Las	it)	-						2. Date of De Month	ath D	ay	Year	3. Time o	
	/Medic		John Charles Ryan								August		2	2009	11:3	87 a <sup>M</sup> .
	Examin	er	4a. Facility Name (If not institution, give 43 Henry Avenue	street and number)			4b. City, T	own, or lert		of Death		1		of Death		
	Funeral		5. Social Security Number 6. S	ex 7. Age	e (In yrs. last	birthday)	if Under 1	1 Year	If Under	24 Hrs.	8. Date of Bir (Month, Da			9. Birthpl	ace (State	or Foreign
	Director		212-32-7305	<b>©</b> M 2□ F 7	4	Yrs.	Months	Days	Hours	Min.	July 1	ı <i>y, Year</i> 4,	935	Mary]	Land	
	nd.		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	www.orlo	nation							10	Od. Inside C	ity Limits
	f sho	ō		220		erto										2 <b>∑</b> No
	the N	Director	Maryland Baltime  10e. Street and Number	Jie	FULL	EI LUI	10f. Zip (	Code				10g. C	itizen of \	What Count	try?	
	3a or		43 Henry Avenue				21:	236				Un:	ited	State	es	
	death	Funeral	11. Marital Status	12. Was Decedent B Armed Forces?	Ever in U.S.	13. V	Vas Decede	ent of His	spanic Ori	gin? (Spe	cify Yes or No Rican, etc.)	)-		ce - America		
36	after , or it	by Fu	1 Never Married 2XXMarried	1XT Yes 2 □ N If Yes, Give	No		Yes 2		Specify:		,			y: Whit		
00	hours tural'		3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates:	1 10	6a Deced	lent's Usual	Occupa	ition			16b		usiness/Ind		
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pu	e file tal Hy d othe	Be (	17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	(First, Middle,	, Maide	n Surnan	ne)		
yla	2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Eventine in unit be notified at	2	Robert M. Ryan								Unknowi					
Mar	12 sh sh and 7 is m traum		19a. Informant's Name/Relationship (				-				i Route Numb				`	
, (e)	1 and Healt tem 2	52	Clara M. Ryan  20a. Method of Disposition	(Wife)			nry Av sition (Nam natory or oth				rton,			1 212. - City or To		
μoι	ages ent of it: If it		1 □XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specific						1					•		and.
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventine must be notified at once.	- 9	21. Signature of Funeral Service Licen		Park	22	Ceme:	Addres	s of Facilit	У					Maryla	illu
ä	any per	7. 1	Vale el	/ *- *		Di	uda-Ri 922 W:	uck ise	Fune: Aveni	ral H ıe D	ome of	Dui Ma	ndall arvla	and 2	222	
			23a Sart 1. Enter the disease comp shock, or heart failure List only	olications that caused one cause on each lir	I the death. D					cardiac o	r respiratory a	rrest,			Approxima Interval Be	te tween
4	Physician		Immediate Cause (Fina disease or condition	CAR	CIN	OW	rA	0	F	17	4/16	R	七千	17	Onset and	ns tus
	/Medical Examiner		resulting in death)	Due to (or as	a consequent	ce of):								-		
	_хатто	-e	Sequentially list conditions,	b. Due to (or as	a consequen	æ oft.									-	
18	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	240.10 (0.40		.,.										
7,0	be executed sician and burial-transit		resulting in death) Last	Due to (or as	a consequenc	ce of):										
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9	ertific ling p e as t	Med	IF FEMALE:	00. 1										· ·		
Box	eath certif attending for use as	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal dea	ath 3 □	Ectopic pro					ĺ		ite of delive onth	,	Year
Ö	that the de ned by the a detached i	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	t time of death	1 5	Joiner (spe	эсну)								
٦,	s that ned b e deta		Part II. Other significant conditions of	ontributing to death be	ut not resulting	g in the ur	derlying ca	use give	n in Part I.		23e. Did t	obacco	use con	tribute to th	e cause of	death?
rds	iw requires that s been signed b should be deta	Completed by	MON INSULL	N De	grenc	210		٠ ر	INC	•	1 🗆 '	Yes :	2 No	3☐ Prob	ably 4□	Unknown
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of	ding Physician: The In. After this certificate har funeral director, page		1 ☐ Yes 2 ☐ No		ent 2 ER/				4 LI NU	irsing Hon				her (Specif)	1)	
no	ding I h. After funer	ţion	27. Manner of Death  1. Natural 5 ☐ Pending  2 ☐ Accident investigation	28a. Date of Inju (Month, Day	y, Year)	b. Time of Injury	M   28	Bc. Injury Work' 1 □ v	raπ ? /es 2 □ l		8d. Describe	now inj	ury occur	rea		
Division of Vital Records,	l or Attend after death Director:	fica	3 ☐ Suicide 6 ☐ Could not be		ury - At home,	farm, stre					8f. Location (	Street	and Numi	ber or Rura	l Route Nui	mber,
Ö	al or safter	Certification: To	4 Homicide determined	building, etc	c. (Specify)						City or To	wn, Sta	te)			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical (		ysician: To the best niner: On the basis o and mapper sta	f examination											(s)
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	10×1		30. Name and address of person who	Ba. (1)	OA 95	a) (Type, 1	Print) EZ/	410	B	Ro	71-0,	NO	M	d.	212	m, 36
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	back	1									

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	· ·		Registrar  1. Decedent's Name (First, Middle	le Last)	CE		Dealli	2. Date of Dea	Reg. No. 🔬 🔰 🛴	3. Time of Death
·	Physicia /Medic	al	IVIN JO  4a. Eacility Name (If not institution	hn Kivers	S	4h City Tower	or Location of Death	Month	Pay Ye	19:30 PM
	Examin	er	4a. Schilly Name (II not institute)	The street and number)	SOTAL	40. Oily, 10Wil,	ALTIN	1001=	40. Oddiny of E	, out
	Funeral Director		5. Social Security Number  066-34-//77  Usual Residence of Decedent	6. Sex 7. Age	e (In yrs. last birthday	/ If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year) 44 9.	Birthplace (State or Foreign Country)
	land ow		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	a-f sh	ctor	MD		KaHin	lore				1 Yes 2 □ No
	or 28	Dire	10e. Street and Number	4		10f. Zip Code	Ø		10g. Citizen of Wha	
	s 23a	Funeral Director	804 Kelgian	12. Was Decedent B	Ever in II C 12	2/2/		pacify Vas or No-	USF.	American Indian,
<b>'</b> 0	fter de ritem	Fun	11. Marital Status  1 □ Never Married 2 Mar	Armed Forces?	No 13	/	Hispanic Origin? (S ban, Mexican, Puert	o Rican, etc.)	Black, V	White, etc.
036	ral", o	l by	3 ☐ Widowed 4 ☐ Divorced			1 □Yes 2 No	Specify:		Specify:	Rlack.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, It. In More I France must be notified any injury or other traumatic event, It. In More I France must be notified any once.	Completed	15. Deceder (Specify only highe	nt's Education est grade completed)	(Giv	edent's Usual Occu e kind of work done	during most of wor	king	16b. Kind of Busin	ess/Industry
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Maryland	uld be Mental arked c	To B	James Kivi	215			Nellie	Jenki	25	
lar	2 short and I is ma	. 0	19a. Informant's Name/Relations	ship (Type. Print)	19b. Mai	ling Address (Stree	A .	ıral Route Numbe	er, City or Town, Sta	te, Zip Code)
	1 and 2 Health em 27		Michael Kive	rs son	20b. Place of Disp	r Kiggs	Avenue	Date	20c. Location - Cit	ror Town State
Baltimore,	Pages 1		20a. Method of Disposition  1 M Burial 2 Gremation		gemetery, cri	ematory or other pla	ace) O/	1/10	Ralling	a Maryland
Ħ.	permit. Pag Department Important: I any injury o		Donation 5 □Other  1. Signature of Funeral Servi	ipecify)	Hrput	22. Name and Add	ress of Facility	40 hn C	troune	Funeral Servi
Ba	permit. Departr Importa any inji		14	5506		1905 Va	rk Zial	1 Croul	timore, 1	W. 4212
			23a. Part 1 Enter the disease, o	r complications that caused t only one cause on each lir	the death. Do not e	nter the mode of dy	ring, such as cardia	or respiratory ar	rest,	Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition		nocardial	infer	Ltion			Onset and Death  Un Kn Cun
	/Medical Examiner		resulting in death)	d.	a consequence of):					-11
	Exammer	7	Sequentially list conditions,	b. Due to (or as	a consequence of:					
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39 x	leath certificate attending physi i for use as the b	Physician/Medic	IF FEMALE:	1						-
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P.O.	the de y the ched	ysic	1 □Yes 2 □No 9 □ Unknown	9 ☐ Unknown	t time of death 5	Ciller (specify)				
σ <u>.</u>	ires that the de signed by the be detached	by Ph	Part II. Other significant conditi	ions contributing to death b	ut not resulting in the	underlying cause g	jiven in Part I.	23e. Did to	bacco use contribu	ite to the cause of death?
ords	w requires been sig should be							1 🗆 Y	/es 2 □ No 3[	Probably 4 Unknown
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<u>ح</u>	ysician: The law is certificate has b director, page 2 s	Completed						perfo	rmed? dea	th?  Yes 2 🗷 No
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Division of Vital Records,	ding Phys After this funeral di	Certification: To	1 ☐ Yes 2 ☑ No 27. Manper of Death	28a. Date of Inju	ent 2 ER/Outpati ury 28b. Time	of 28c. Inj	4 🗆 Nursing r	1	dence 6 Other now injury occurred	(Specify)
ion	nding ath. :: Afte e fune	atior	1 ☑ Natural 5 ☐ Pendi 2 ☐ Accident invest	ng <i>(Month, Ďa</i> igation	y, Year) Injury		ork? □Yes 2□No			
Vis	I or Atten after deatl Director: I in by the	tifica	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	mined   28e. Place of Hiji	ury - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (S		or Rural Route Number,
Ω	urs aff rral Di									
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical		ing Physician: To the best I Examiner: On the basis o and manner sta	of examination and/or					
	To the	Me	29b. Signature and title of certific				nse number		29d. Date signed (/	Month, Day, Year)
			> m t	W. W.		DY	7353		July 30	, 2009
	(p./		30. Name and address of person	who completed cause of c			D 11.		1.	1 21229
	- V		31. Date filed (Month, Day, Year	MO 900	Caton /	Wenve	Baltin	ore, p	lary land	1 4667
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2009 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) JULY 30 Day **Physician** 2009 2:10 A M BETTY SUE RUSSELL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HARFORD FOREST HILL HEALTH AND REHAB CENTER FOREST HILL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 ☐ M 2 🗓 F 1935 North Carolina 5, Director 73 223-44-8752 Usual Residence of Decedent I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

Tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I'm Medical Evancium counts to mother 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Funeral Director Harford Maryland Street 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21154 3146 Forge Hill Road 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Completed by 3 N Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Transportation 12 School Bus Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nona Edith Waddell Doyle Leeson Crabb ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2003 Highfield Ct., Forest Hill, Maryland 21050 Lew A. Carter / Nephew permit. Pages 1 a
Department of He
Important: If Item
any Injury or othe
once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Marial 2 ☐ Cremation 3 ☐ Removal from State 8/3/2009 Bel Air, Maryland Bel Air Memorial Gdn. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature Funeral Service Li 50 W. Broadway, Bel Air, Maryland 21014 Approximate Interval Between Opset and Death 23a. Part 1. Enter the disease, or conscious that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 0 Physician AY disease or condition resulting in death) /Medical Due to (or all a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi CARCINOM resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the pest 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) signed by the a 1 □Yes 2 🗷 No o 9 Unknown ۳. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should I 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has l page 2 s autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To this To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner death 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred After atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT DUNCAN-615 W. MACPHAIL RD. - BEL AIR, MD 21014 31. Date filed (Month, Day, Year) AUG U4 2009 32. Registrar's Signature State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2009 NORMAND ARTHUR RABOIN /Medical County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) **Examiner** HARFORD 1Air Healthand litation (enter If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 M 2 ☐ F 20, 1921 Rhode Island Director 039-09-7053 85 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show or 28a-f show notified at 1 ☐ Yes 2 ▼No Director Maryland Baltimore Baldwin 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ral", or items 23a or Examiner must be r 21013 USA 13713 Pleasantville Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. 72 hours after 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed by 3 Widowed 4 □ Divorced White "natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 7.

Mental Hygiene.

narked other than "n Elementary/Secondary (0-12) College (1-4or 5+) 12 Petty Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and M-Important: If them 27 in any injury or critical any injury or critical any injury or critical any injury or critical any injury or critical any injury or critical any injury or critical any injury or critical any injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or critical and injury or cr n and Mental မ Edward Raboin <u>Ogna Agnes</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. Box 10028, Baldwin, MD 21013 Michael DiPaula / Nephew 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 ☐ Cremation 3 🛮 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-31-09 Hanover, PA Olivet Cemetery of Funeral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 aused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, such has 23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause Immediate Cause (Final House Physician disease or condition resulting in death) /Medical for as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) Of MAAD \*\* Kabo\I pivision or Vital Records, P.O. Box 68760, IF FFMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? patributing to death but not resulting in the underlying cause given in Part I. Other significant conditions Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has be rector, page 2 s autopsy performe 2 No 25. Was case referred to medical examiner? director, 26. Place of Death Check onl one Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No P 2 ER/Outpatient 3 DOA 1 🔲 Yes this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Medical Certification: After 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident Funeral Director: rely filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only within 24 h To the Fu one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title

State Registrar lame and add

31. Date filed (M

Impleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

308

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 for State Registra Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 1:50 AM 2009 ncia County of Death or Location of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town Battimore N Boyview Hopkins Birthplace (State or Foreign Country) If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Social Security Number Year Months Days Hours Min 1 □ M 2 🖼 60 214-52-0533 Usual Residence of Decedent Yrs Van 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Dres 2 No Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA edella 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 1 ☐ Yes 2 ☑ No 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) tate of Maryland Elementary/Secondary (0-12) College (1-4or 5+) Collections 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) -Sor 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses proximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Serity that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Jrhknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 2 No 1 ☐Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 □Yes 2 □ No 2 Accident

Physician: The law requires that the death certificate be executed P.O. Records, Vital ō Division Hospital or Attending **Physician** 

Examiner

**Funeral** 

Director

show

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Maryland 21215-0036

altimore,

Item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the "hodical Eventian" and be natified at

of Health and Mental Hygiene.

permit. Pages 1 Department of h Important: If Ite any injury or ot

Physician

/Medical

Examiner

attending physician and for use as the burial-transit

sate has been signed by the page 2 should be detached

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Funeral Director

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Be Completed

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Examine

by Physician/Medical

Completed

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Certification:

Medical

/Medical

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

3 Suicide

29c. License number D14823 29d. Date signed (Month, Day, Year) 214169

Donging 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

BALTIMORE, MD21215 THADA, M.D. 5356 REUTERSTOWN RD B0014010

Registrar

6 ☐ Could not be

facili

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ) Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death August 2, Day 2009 Physician 10:38A Alfreda S. Swetz /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Balto. Stella Maris Hospice Timonium 8. Date of Birth (Month, Day, Year) June 24,1924 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday Funeral Hours Months Days 1 □ M 2 🛣 F Maryland 85 Director 216-18-3515 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 1 ☐ Yes 2√ No Director Md. Balto. Nottingham 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21236 4313 Soth Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \( \text{Yes} \) 2 \( \text{N} \) No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∏Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2 📉 No Specify: White Specify: Completed by 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 10th Beauty Salon Hair Dresser 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stefan Sawicki Alesandra Mazurkiewicz ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12919 Dulaney Valley Rd. Glen Arm, Md. 21057 Paul A. Swetz, Jr. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 8-6-2009 Parkville,Md. Parkwood 4 ☐ Donation 5 ☐ Other (Specify) Schimunek Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the diserse, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failir re. List only one cause on each line. Immediate Cause (Fin A disease or condition resulting in death) **Physician** PLASMACYTOMA /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause of injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 📉 No 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 MNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 X No 1 ☐ Yes 2 □ No 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6 XOther (Specify) HOSPICE Hospital: 1 ☐ Yes 2 📆 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifier

(Check only one X Nurse Practitioner) To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one X Nurse Practitioner) The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

28a-f show

Department of Health and Mental Hygiene. Important: yor items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Extrainer most be notified at

Examiner

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Hospital or Attending

death.

24 hours after death Funeral Director:

within 2.

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Division of Vital Records,

ALFREDA SWETZ

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Baltimore, Maryland 21215-0036

2009

AUGUST

State Registrar 31. Date filed (Month, Day, Year).

30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

JACKIE JONES, CRNP



29d. Date signed (Month, Day, Year)

TIMONIUM, MD 21093

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Margaret V. Stevanus 3,2009 8:55A August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Timonium Balto. Stella Maris ocial Security Number Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1□ M 2🛂 F Months 234-46-8154 76 Yrs. West Virginia June 6,1933 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location ภ เกตก "natural", or items 23a or 28a-f show It e Nedical Exp. แกะกามสามารถเปลี่ยน 21 1 ☐ Yes 2 No Director Md. Balto. Nottingham 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 8524 Vollmert Avenue 21236 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 XYes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify. Specify: White ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner Perry Hall Janitor Service is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental William F. Orr Anna Mae Stewart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health au
Important: If Item 27 is
any injury or other trau
once. DTR. 10807 Pfeffers Rd. Kingsville, Md. 21087 Elizabeth Stevanus Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview 8-4-2009 Baltimore City, Md. 21. Signature of Funeral Service Lice see 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart falloge. List only one cause on each line. Immediate Cause (Fin I disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) attending physician a Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 3 Ectopic pregnancy 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknow signed by the detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has nerforme this certificate 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No **Division of Vital** Hospital or Attending Physician: 24 hours after death. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No hin 24 hours after death the Funeral Director; completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier To the within 7 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

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State Registrar RD TIMONIUM,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day Edna Virginia Sconion 30 2009 44 14 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Harford Memorial Hospital Havre De Grace Balto Co 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5-29-1930 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Days 1 □ M 2 🗙 F 212-28-0432 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Harford MD Aberdeen 1 ☐ Yes 2X No 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 429 Oak Street 21001 USA 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 3 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 No Specify. Black Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled llth grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James I. Hawkins Emily Kelly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) Street Aberdeen, MD 21001 Ella M. Derrien-Daughter Date 20c. Location - City or Town, State 20a. Method of Disposition Havre Grace, MD 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State St James Cemetery 8-3-2009 4 ☐ Donation 5 ☐ Other (Specify) March East 22. Name and Address of Facility 21. Signature of Funeral Service Licensee S 1101 E. North Avenue Balto, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ACUTE MYDEARDIAL IMFARCTION disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events Due to or as a consequence of) resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DIABETES MELLITUS 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown ITYPERTENSION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No CVA autonsy performed? 1∐ Yes 2**/**No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 MER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation

physician and s the burial-transit Division or Vital Records, P.O. Box 68760, CONION, After this certificate has al or Attending F after death. after death.

Hospital

Examine Physician/Medical þ Completed Certification: To within 24 hours at To the Funeral C Medical

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

**Funeral** 

Director

is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. The terms 23a or 28a-f show item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and Department of Healt Important: If item 27 any injury or other tonce.

**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0036

2 Accident 3☐ Suicide

6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only 29b. Signature and title of pertifier

29a. Certifier

4 Homicide

D45344

29c. License number

29d. Date signed (Month, Day, Year)

saw MD 30. Name and add ear of person who completed cause of death (Item 23a) (Type, Print)

MD, 6225. UNION ANE, HAVRE DE GRACE, MD 21078
39. Registrar's Signature

State Registrar

31. Date filed (Month, Day, Year) AUG 0 4 2009

DHANJANI



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 200 9 Year Month Day **Physician** Raymond Schw.
4a. Facility Name (If not institution, give street and number) Schwartz 12 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner University of Maryland Hedical Conte 5. Social Security Member 6. Sex 7. Age In vis last hirther Balhmore N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1**X**) M 2□ F 67 Nov. 214-38-7420 Director Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show r than "natural", or items 23a or 28a-f sho Director MD 1 ☐Yes 2 No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1717 Willis Drive 21227 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 10 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status 1 Never Married 2 Married 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 □Yes 2**X** No Specify: White Specify ⋛ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within / Elementary/Secondary (0-12) College (1-4or 5+) Brewer Beverage Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raymond Leo Schwartz Carvella Carback ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1717 Willis Drive, Baltimore, MD 21227 19a. Informant's Name/Relationship (Type. Print)

Janet Schwartz - Wife permit. Pages 1 and 2 s
Department of Heath au
Important: If item 27 is
any Injury or other trau
once. 20b. Place of Disposition (Name of Meadlow 1dge) Menior 1a1 Date 20c. Location - City or Town, State Method of Disposition Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 8-4-2009 Park Elkridge, Maryland Tuffe(al 3-rvice 1) Name and Address of Facility Ambrose Funeral Home, Inc. leve 1328 Sulphur Spring Rd., Arbutis, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Pulmonary /Medical Due to (or as a consequence f): Examiner roum negative Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Die to (or as a consequence of) physician and the burial-trans Due to (or as a consequence of) Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Vear Day 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 ☐ Unknown ģ s been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s has certificate 1 □ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

or Attending Physician: The law requires that the death certificate be execute Box 68760, Ö ٦. Division of Vital Records, 24 hours after death.

Funeral Director: After this certific letely filled in by the funeral director, Hospital completely within 2 To the

with the

death v

filed within 72 hours after

Baltimore, Maryland 21215-0036

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of centifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore

5 weet

State Registrar

31. Date filed (Month, Day, Year) AUG 0 4 2009

Grea

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Stevenson **A**rnetta August a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Baltimore If Under 24 Hrs. If Under 8. Date of Birth (Month, Day, 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Min Hours 1 □ M 2 🔀 F 216-42-4779 66 Director February 17, 1943 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Windsor Mill 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3505 Milford Mill Road United States Funeral 21244 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Evar 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Black 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Communications Telephone Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stanley L. Stevenson 2 Erma Parker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shaunta M. Chester/Daughter 3505 Milford Mill Road Windsor Mill , Maryland 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State August 3 1 ☐ Burial 2 🖺 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Metro Crematory, Inc. Baltimore, Maryland 22. Name and Address of Facility Amanda Heaston Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cong unknown /Medical Due to (or as a nsequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of) spital or Attending Physician: The law requires that the death certificate be executed ours after death.

neral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burlal-transit Division of Vital Records, P.O. Box 68760,lphaDue to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month 5 Other (specify) Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 neumoni 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 **X**No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) (+0 \( \text{FO} \) ( \( \text{Expecify} \)) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) Columbia MD Cedar gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2:104 M **Physician** 31 2009 eronica /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harwood Year Hunder runde n yrs. last birthday) 74 Yrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** Year) Days Min 1 □ M 2 🗹 -13-1934 216-32-7216 Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If Medical Exantment Exantment Control of the profiled at 1 Yes 2 No Director Himore MD 10g. Citizen of What Country? 10e. Street and Number USA daewood Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black ò 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) ohns vid Rural Route Number, City 19a. Informant's Name/Relationship (Type. Pri t) 19b. Mailing Address (Street and Number or Youn 3altimore. 20b. Blace of Disposition (Name of demetery, crematory or other) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 5151 Baltimore National 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to for as a consequence of Exami Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) attending physician for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Ye ar in the past 12 months?
1 ☐ Yes 21 No
9 ☐ Unknown 5 ☐ Other (specify) signed by the a P.O. 9 \ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been si, , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No certificate 2 No 1 □ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of D ath 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. License number 29d. Date signed (Month. Dav. Year) 29b. Signatu

State Registrar Name and addr

31. Date filed (Month, Way

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 0840 hrs **Medical Examiner** Small August 1, 2009 Robert 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** 235 South Castle Street If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral oreign Months Director Country) Maryland 05/14/1939 1X M 2 F 70 219-26-9469 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 No Baltimore Maryland Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? United States 235 S. Castle Street 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 Married Yes 2 X No Yes 2X No specify: White If Yes, Give Year Specify: Widowed 4 X Divorced ⋛ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Dccupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) MD 21215-0036 the Medical Health Insurance Accountant +6 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) th and Mental F Robert Leroy Small Agnes Sophie Iskiewicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8555 Falls Run Road Ellicott City, Maryland 21043 Timothy Michael Small - Son partment of Health portant: If item 2' ury or other traum

Physician /Medical Examiner 20a. Method of Disposition

4 Donation 5 Other Specify:

1 XX Burial 2 Cremation 3 Removal from State

Could not be

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32 Registrar's Signature

Suicide Homicide

29b. Signature and title of certifie

Ana Rubio MD.

31. Date filed (Month, Day, Year)

29a. Certifier (Check only

Medical

State Registrar

Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical Division of Vital Records, P.O. Box 68760, Be Completed by this Certification: Director: 1 in by the f within 24

21. So nature of Funeral Service Licensee	David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryla	nd 2123
failure. List only one cause on each line.	Bet	roximate Interva ween Onset and Death
Immediate Cause (Final disease or condition resulting in death)  a. End-stage renal  Due to (or as a consequence of):	disease	
b		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or highly that hitlated		
events resulting in death) Last Due to (or as a consequence of):		
d. 232 27 pa	rmE, g894 8/11/09 TT	
X UNPENDED AMENDED 234,27, PE	ImE, 8094 0/11/09 11	
IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery	
23b. Was decedent pregnant in the past 12 months?  1 Live birth 4 Pregnant at time of death 9 Unknown		Year
Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I. 23e. Did tobacco use contribute to the car	use of death?
	1 Yes 2 No 3 Probably	4 🗸 Unknown
	24a. Was an autopsy 1 prior to complet death?  1 ✓ Yes 2 No 1 ✓ Yes	
25. Was case referred to medical	26.Place of Death (Check only one)	
examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/O	utpatient 3 DOA Other Nursing Home 5 Residence 6 ✔ Other: Scen	e
27. Manner of Death  1X Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year)  28b. 28b. 3	Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred  1 Yes 2 No	

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

29c. License numbe

O.C.M.E.

20b. Place of Disposition (Name of cemetery, crematory or other place)
Saint Stanislaus
Cemetery

DHMH 17 Rev 1/2001 **OCME 2006** 

ORIGINAL

28e. Place of Injury - At home, farm, street, factory, office building, etc.

20c. Location - City or Town, State

28f. Location (Street and Number or Rural Route Number, City

August 1, 2009

29d. Date signed (Month, Day, Year)

08/06/2009|Baltimore, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 10e, perFH g895 9/3/09 TT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Year Audrey Irarhom 2231 2009 9 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b City Town, or Location of Death Examiner Union Memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2F Months Days Hours Min. Yrs. 12-8-1936 Director 212-34-1955 MD Usual Residence of Decedent death with the Maryland 10a. State 10b. County Show 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23a or 28a-f shov the Modical Examiner must be notified at XXYes 2 No MD Directo N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 88f N. Castle Street 21205 U Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Yes 3/No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black þ 1 ☐ Yes 2 XNo Specify: Specify 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working Pages 1 and 2 should be filed within nent of Health and Mental Hygiene ont: If item 27 Is marked other then ' Elementary/Secondary (0-12) College (1-4or 5+) Johns Hopkins Hospital Escort Services 12th grade N/A it of Health and Mental Hygi If item 27 is marked other or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Samuel Carter ٥ Virginia Madison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Stewart-Sister 4314 Groveland 20b. Place of Disposition (Name of crematory crematory or other place) alto, MD 21215 20c. Location - City or Town, State Avenue Balto, MD 20a. Method of Disposition Date Arbutus Memoral 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: If any injury or once. ŏ 8-6-2009 Arbutus, `4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, Qu Wane-21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician 10 /Medical Due to (or as a consequence f): Examiner entricular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death signed by the a 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ sete has been signi page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes № No 1 ☐ Yes 2 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Certification: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 🗌 Inpatient 2 ER/Outpatient this 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 2 Accident investigation М 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner staged. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cadse of death (Item 23a) (Type, Print) Memorial Hospital Union 32 Registrar's Signature 31. Date filed (Month, Day, Year) back State AUG 0 4 2009 breeze Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 16b, 20a-c, 22 perFh 8894 8/11/09 TT

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day 2009 July 19, 7:52 AM M Bernard Vandermark 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore 8821 Winands Road Randallstown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Dec 12, 5. Sociat Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign New York 1⊠M 2□F 1964 116-66-9467 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8821 Winands Road 21133 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Unit (Give kind of work done during most of working life. DO NOT use retired) Etementary/Secondary (0-12) College (1-4or 5+) 12 electrical Self-employed 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) Elizabeth Vandermark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6401 York Road; Baltimore, Maryland 21212 Laura Bertino/social worker 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 23 Name and Address of Facility Wylie F.H. 4 □Donation 5 to Other (Specify) in state Mt. Zion Cem. Lansdowne MD 638 N. Gilmor 21. Signature of Funeral Service Li Milector Wade, Street 222 Baltimore, Maryland 21201 21217 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) KESPINATOR < CMIN Due to (or as a consequence of): emplications Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1□ Yes 2⊠No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how intury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No

Examine The law requires that the death certificate be executed ig physicien and as the burial-transit Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical ettending for use as signed by the e s certificate has the lirector, page 2 s To the Hospital or Attending Physician: this certific al director, Be ို Director: After the Certification: death. efter within 24 hours ef To the Funeral D completely filled in

**Physician** 

/Medical

Examiner

10a. State

MD

Direct

Completed by Funeral

Be

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**Funeral** 

Director

in then "natural", or Items 23a or 28e-f show the Medical Examinar must be notified at

the Maryland

With

death

Pages 1 and 2 should be filed within 72 hours after

alth end Mentel Hygiene. 27 is marked other than ' ir trsumatic svent, the Ma

Health Item 27 i

permit. Pages 1 Department of H Important: If Its any injury or ot once.

**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0036

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (unack only one) and manner stated. 29b. Signature and title of certifier 29c. License number

State Registrar

Medicai

Attending

29d. Date signed (Month, Day, Year)

JULY 23, 2009

MILLS. MI) ZIII)

Name and address of person who completed cause of death (Item 23a) Type, Print) NUSSROADS E(ALMO

31. Date filed (Month, Day, Year) 32 Registrar's Signature AUG 0 4 2009 barke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician Juli 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Parkull nue Itimore 8. Date of Birth (Month, Day, May 3 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 □ M 2 🛛 F Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exam her must be notified at once. 10a. State 1 ☐ Yes 2 👿 No Director Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21234 Inited 2910 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐Yes 2 X No Specify: þ white 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Uhite Ford Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) buse 2910 Ontario Avenue Whiteford mD 21234 Yarkulle. charles M. Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Tackwood Cemetery Hug 4, 2009 22. Name and Address of Facility
Evans Funeral Chapel + C
8800 Harford Road pel + Cremation Services 21. Signature of Funeral Service Licensee Parkuille 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) concer Weel. Physician -una /Medical Due to (or a sharequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trai Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical use as IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 9 Unknown reate has been signed by the page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 □Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A filled in by the 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and a 0 Addro MO chard 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2 U U 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ,2009 Frank W. Weber July 30 1:55 p <sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Rock Spring Village Harford County Forest Hill If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) i. Social Security Number A 705–05–6665 **Funeral** 1**№** M 2□ F Months Maryland Director 92 Feb. 28, 1917 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinor must be notined at Maryland Harford County Bel Air Director 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1824 Prindle Drive 21015 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces 1 Tyes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify Specify: White **3** Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Railroad Worker Chessie System Baltimore, Maryland 17. Father's Name (First, Middle, Last)
William Weber 18. Mother's Name (First, Middle, Maiden Surname) Anna Hoffman 19a. Informant's Name/Relationship (Type. Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1904 Cosner Road, Forest Hill, Maryland 21050 Mr. Frank J. Weber (Son) 20a. Method of Disposition
1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Middletown Un. Meth. Freeland, Maryland 08/07 2009 4 □ Donation 5 □ Other (Specify) 21. Signatifie of Funeral Service Licensee Evans Funeral Chapel & Cremation Services -BelAir 3 Newport Drive, Forest Hill, Maryland 21050 can of John 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician -ardiac disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examiner day hading to introducause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be execute burial-trar Due to (or as a consequence of): as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes of Vital 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? al or Attending P s after death. 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 24 hours a To the Hospital within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar' Signature

aurence Di white

0 4 2009

31. Date filed (Month, Day, Year)

th (Item 23a) (Type, Print)
615 W. MacPlant # 206 Bel ATL MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Day Physician Nathaniel 1/atson 9UGUST 3 2009 12:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 2537 McCULLOH STREET If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months XXM 2□ F Yrs 1942 MARYLAND Director 66 AUG. 24 216-36-2387 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinations the notified at 1 XYes 2 No Director BALTIMORE MARYLAND N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21217 2537 McCULLOH STREET Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2√T√No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗵 No Specify. \$ Specify: BLACK 3XXWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If Item 27 Is marked other than "any Injury or other traumatic event." Elementary/Secondary (0-12) College (1-4or 5+) HOME IMPROVEMENT MASTER PLUMBER 9th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CALLIE PENDERGRASS ပ PRYOR WATSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2537 McCulloh St., Baltimore, Maryland 21217 Pry Watson Jr./Son 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 08-05-09 21. Signature of For eral Sylve sacetise 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Moun 1206 W NORTH AVENUE Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 14 ardiovascular **Physician** pertensive Years /Medical Due t (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 | Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? after death.

Director: After this certificate 1 ☐Yes 2 ☐No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

DHMH 17 Rev 1/2001

we S. parks

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alexander

31. Date filed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year **Physician** 2009 9:20 pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2514 QUANTICO AVE. BALTIMORE N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral XXM 2 F Months Days Hours Director 94 MAY 5, 1915 SOUTH CAROLINA 155-05-8791 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at Director 1 X Yes 2 No MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2514 QUANTICO AVENUE 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐Yes Z No
If Yes, Give
Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married XX Married Maryland 21215-0036 1 Yes 25 XNo Specify: <u>م</u> Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Mence Jones. Elementary/Secondary (0-12) College (1-4or 5+) 3rd grade LABORER BURLINGTON MILLS. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ DOZIER WALLACE BAZZELL GOODMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucille Wallace Deloach/Daughter 210 Overlook Ct. Falmouth, VA., 22405 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (incline of confidence of the place of Disposition (incline) and the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the p 1 X Burial 2 ☐ Cremation 3 Removal from State DARLINGTON 08/08/09 4 ☐ Donation 5 ☐ Other (Specify SOUTH CAROLINA Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part 1. E that the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Wovasc 40 Mins. disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine as a consequence of) or Attending Physician: The law requires that the death certificate be executed as the burial-trar attending physician and resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 □Yes 2 □ No. 9 Unknown as been signed by 2 should be detach significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page certificate 1 □Yes 2 No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 □ No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 1 🔲 Inpatient 5 Residence 6 □ Other (Specify) After this funeral 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 🗌 No Director: 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier Bultimore, MDZ121 DRC. U FOMA lowar 31. Date filed (Month, Day, State ALIC 0 4 2000 Registrar

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09-05978	
Lamont Woodard	

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State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		ficate of Deat	th and Mentari th		. No.	9 248/
Physicia Medical Examin	n/	Decedent's Name (First, Middle, Last)	4	OODF	ARD	2. Date of Death	Day Year	3. Time of Death 0101 hrs
		4a. Facility Name (if not institution, give street and University Hospital	number)	4b. City, Baltir	Town, or Location of Dea		4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex  2/7-74-80/6 1 M 2 F  Usual Residence of Decedent	7. Age (In yrs. last	birthday) If Und Montr	er 1 Year   If Under 24H ns Days Hours M		(MM/DD/YYYY) 9. Bird Foreig Co	
d iow any		10a. State 10b. County		wn or Location	nne			10d. Inside City Limits 1 Yes 2 No
e Maryland or 28a-f sh		MARYLAND N/A  10e. Street and Number  3905 WADASA	2	10f. Zip		100	g. Citizen of What Cour	
ath with th tems 23a	Funeral [	11. Marital Status 12. Was D	ecedent Ever in U.S. Forces?	13. Was Decede	ent of Hispanic Origin? (		14. Race - Ameri White, etc.	can Indian, Black,
rs after de	2	3 Widowed 4 Divorced if Yes, Give Y or Dates:  15. Decedent's Education (Specify only highest gr	'ear		No specify: Occupation (Give kind o	fwork done	Specify: 3	LACK
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Completed		(1-4 or 5+)		rking life. DO NOT use re			Company
21215-0036 Juld be filed within 7 Mental Hygiene marked other than cevent, the Medica	8	17. Father's Name (First, Middle, Last)  1. A S S A U	Woo	odard	Bobk		w	right
MD 2's bould 2 should alth and Me m 27 is ms aumatic en	٩	19a. Informant's Name/Relationship (Type, Print) Bobbis Wright (			S (Street and Number o			, Zip Code)  YD 21215  Town, State
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene, Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 VBurial 2 Cremation 3 Removal  4 Donation 5 Other Specify:	r o. l crer	matory or other place	ial Park DE	3/07/2009	Battimo.	re, Maryland
V.		21. Signature of Funeral Service Licensee	Ollian	22. Name and 505€P	H H. BROW FULTON A	N JR. F NE, BALTI	MORE, M	HOINE Delai7
Physician /Medical xaminer		100	Sunshot Wounds		of dying, such as cardiac	or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and Death
	e.	Sequentially list conditions, b.	s a consequence of):					
ed sit	Examiner	(Disease or injury that initiated events resulting in death) Last	a consequence of):					-
760, Icate be executed physician and the burial - transit	Medical	d.  UNPENDED AMENDED	)					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans		23b. Was decedent pregnant in the past 12 months?	s, outcome of pregnan b birth gnant at time of death	2 Fetal death	3 Ectopic preg	nancy	23d. Date of deliver	/ Day Year
P.O. BO.	P S	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing	to death but not resul			23e. Did tob	acco use contribute to	the cause of death?
ords, P.O.  w requires that the s been signed by should be detach	ompleted by	-				24a. Was ar		topsy findings available
of Vital Records, ag Physician: The law requinular the three remains or the continuent director, page 2 should	ပြု	25. Was case referred to medical			26.Place of Death (Chec	autops perform 1 ✓ Yes 2	ned? death?	es 2 No
Vital ysiciar his cert directo	ě	examiner? 1 ✓ Yes 2 No	Inpatient 2 🗸 ER		IOthor:		esidence 6 Other	:
ion of trending Pheath.	ation: T	27. Manner of Death 28a. Dat	th Day Year)	Bb. Time of Injury 035 hrs	28c. Injury at Work?  1 Yes 2 ✓ No	28d. Describe ho Subject shot	w injury occurred	
Division  To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined (Specification)	ace of Injury - At home  y) Local Street	e, farm, street, factory	/, office building, etc.	or Town, Sta		ral Route Number, City , MD
To the Hospital within 24 hours To the Funeral completely filled	Medical	29a. Certifier (Check only one) 2 Medical Examiner:On the basis and manner	s of examination and/o					
	Σ	29b. Signature and title of certifier		29	O.C.M.E.		29d. Date signed (Mo July 31, 2009	nth, Day,Year)
HV			Medical Examin	er 111 Penn	Street, Baltimore, I	MD 21201		
Sta Registra	_	31. Date filed (Month, Day, Year) 32. F	egistrar s Signature	barles	9			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 20b & 22 State of Maryland 20e partment of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** Rosalind Williams July 9, 10:31 AM <sup>M</sup> 20Ó9 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fort Washington Hospital Fort Washington Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Funeral 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🔯 F 578-84-2071 Yrs. Director 58 Sept 11, 1950 Washington DC Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hygiene.

arked other than "natural", or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Prince George's 1 ☐ Yes 2√ No Director Fort Washington 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 10850 Indian Head Highway #316 20744 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ∐Yes 21∑ No Completed by Specify black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 caregiver geriatrics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Russell Williams ပ္ Ella B. Morris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHerry Williams/daughter 2323 Good Hope Court SE #301 Washington, DC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection 7/24/2009 8000 Woodyard Rd 4 ☐ Donation 5 (Spec in state 22. Name and Address of Facility MCLaughlin F.H. 2019 Martin Luther 21. Signature of Feral Service king Ave, SE washington, DC 20020 Konald 23a. Part It Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as Examine attending physician and for use as the burial-trar Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 3 Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 □ Yes 2 No
9 □ Unknown Month signed by the a Id be detached fo 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed s certificate has the irector, page 2 s Be Certification: To

Hospital or Attending Physician: The law requires that the death certificate be execute Division of Vital Records, P.O. Box 68760, within 24 hours after death

To the Funeral Director;
completely filled in by the

Baltimore, Maryland 21215-0036

					24a, Was an autopsy performed? 1 □Yes 2 □No	24b. Were autopsy findings availabl prior to completion of cause of death?  1 □ Yes 2 □ No		
25. Was case referred to medical examiner?				26. Place of D	eath (Check only one)			
1 Yes 2 No	Hospital: 1 ☐ Inpat	ient 27 ER/Outpat	ient 3 🔲 I	Home 5 ☐ Residence	me 5 ☐ Residence 6 ☐ Other (Specify)			
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigat				28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injur	y occurred		
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	d 28e. Place of Ir	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street ar. City or Town, State	28f. Location (Street and Number or Rural Route Number, City or Town, State)		

29c. License number

State Registrar

Medical

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

04/182 8507 you HILA HOUZ FOR WAShinghes

31. Date filed (Month, Day, Registrar's Signature Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death lonth Physician /Medical 4c. County of Death Facility Name (If not institution, give street and number) City, Town, or Location of Death Examiner 14155 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Pennsylvania 8. Date of Birth Sept. 28, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Yea 1916 Days Min. 1 □ M 2**X**XF Months Hours 92 177-10-3652 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene.
em 27 is marked other than "natural", or items 23a or 28a-f show wither traumatic event, the Medical Evancher must be notified at 10a. State 10c. City. Town or Location Director 1 ☐ Yes 2 🙀 No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5400 Vantage Point Road 21044 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 □Yes 21☑No Specify Completed by Specify: White 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be P Robert Raymond Gehrett Florence Eva Pentacost 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert E. Samuelson Son 302 Butterfly Drive, Taneytown, MD 21787 other ! 20b. Place of Disposition (Name of cemetery, crematory or other place)
Scottsville Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Pages 1
Department of H
Important: If iter
any injury or oth 11√∑ Burial 2 □ Cremation 3 □ Removal from State Scottsville, VA 8-2-2009 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Witzke Funeral Home, Inc. 555 Twin Knolls Road, Columbia, MD Approximate Interval Between Onset and Death 23a. Part I. Enter the se se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 14 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part JJ. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 res 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I funeral director, page 2 s autopsy performe 2 No 1∏Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

completely

(Check only one)

29b. Signature and title

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

and manner stated.

08

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 00:20 AM MATTIE 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SCHUS HOPKINS BAYVIEW MEDICAL CENTER BARMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Year) 919 1 □ M 24 □ XF 89 AL Director 422-26-2641 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shov The Medical Examinat must be notified at AL Birmingham 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 35235 USA 2903 Hunter Ridge Ct. Apt. 104 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 □Yes 2XXNo Specify: Specify: Black 2 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation within 72 (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+)  $N \not A$ permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Secondary (0-12) 8th Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Thompson Carrie Baker ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dorothy Jenkins-daughter 3413 Dudley Avenue Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ò 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 8-1-2009 injury o Eden Hills Cem Anniston, Alabama 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MARCH FUNERAL HOME-EAST Wan MD 21202 Approximate 1101 E. North Avenue Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RESPIRATORY FAILURE 10 mw /Medical Due to (or as a consequence of): **Examiner** STROKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner tue to for an expression or off requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. the 9 Unknown 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an has page 2 autopsy performe certificate 2 No 1 ☐ Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Medical Certification: After 1 Matural 5 Pending investigation death. 1 ☐Yes 2 ☐No after death Director: / d in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

within 2

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, 32. Registrar's Signature

4940

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EASTONN

29c. License number

2E3-000

AUENUC

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Day Year 2009

00:03 A M

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 No

Maryland

4c. County of Death

10g. Citizen of What Country?

14. Race - American Indian,

Black, White, etc.

Specify: White

Wallpaper Company

20c. Location - City or Town, State

Baltimore, MD

Barclay

16b. Kind of Business/Industry

Year)

1918

USA

Anne Arundel

1. Decedent's Name (First, Middle, Last) Month 8 **Physician** Vivian Frances Wessel /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 7789 Poplar Grove Road Severn If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 □ M 2 🗓 F 216-05-6450 **Director** 91 Jan. 11, Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. If item 27 Is marked other than "natural", or items 23a or 28a-f show 10a, State 10h County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Funeral Director MD Anne Arundel Severn 10f. Zip Code 10e. Street and Number 7789 Poplar Grove Road 21144 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No þ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Interior Decorator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Unknown ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7789 Poplar Grove Road Severn, MD 21144 Howard Peterson Friend it of Healt If item 27 or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State tment 4□Donation 5 ØOther (Specify) Entombment Loudon Park 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee M00918 Services 1 2nd Avenue S.W. Glen Burnie MD 21061 allu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MYOCAPLIAL 10 farction **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner STROKE Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Box 68760

the burial-transit page 2 should be detached certificate

o

Records,

of Vital

Division

death. after death

or Attending Physician: The law requires that the death certificate be executed filled in by within 24 hours a

To the Funeral Hospital the

Approximate Interval Between Onset and Death Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 12 No 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 1∐Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 050760 40 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STE 307, LUTHERUITE, UND 21093 CHARLES WEN 6 7 YORK Rd. 140

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Dana Paul Weinkam

ına Paul Wein		State of Maryland / Department of Health and Mental Hygiene  1- For State Registrar  Certificate of Death Reg. No.  2009 2487
Physicia ledical Exami	an/	1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month  Day  Year
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
Funeral		105 Grason Road  Glen Burnie  Anne Arundel  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year   If Under 24Hrs.   8. Date of Birth (MM/DD/YYYY)   9. Birthplace (State or Foreign
Director		213-76-5945   1XM 2 F   52 Yrs.   Months Days Hours Min.   Nov. 1, 1956   Maryland
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
<b>*</b> .*	ō	Maryland Anne Arundel Co. Glen Burnie
ith the Maryland 23a or 28a-f sho	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
vith the s 23a o e notifi		105 Grason Road 21061 United States  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,
after death with the Maryland al", or items 23a or 28a-f shiner must be notified at once	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.
rs after ural",	þ	3 Widowed 4 Divorced If Yes, Give Year Vietnam 1 Yes 2 X No specify: Specify: White  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry
215-0036 be filed within 72 hours ntal Hygiene. rked other than "natur: ent, the Medical Exami	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+)
5-0036 led within 72 Hygiene. other than the Medical	omp	12 yrs.   Carpenter   Remodeling  17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Surname)
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	BeC	Vernon William Weinkam, Sr.  Veronica Cecilia Sudbrink
Me Me	70	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
, MD and 2 sho ealth and tem 27 is		Mrs. Deborah J. Weinkam / Wife 105 Grason Road Glen Burnie, MD 21061  20a. Method of Disposition   20b. Place of Disposition (Name of cemetery,   Date   20c. Location - City or Town, State
Baltimore, permit. Pages I an Department of He important: If ite		1 Burial 2 Cremation 3 Removal from State crematory or other place)
altin mit. Pa partmei portan ury or		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Singleton Funeral & Cremation
	9	M01121 Services PA; 1 2nd Ave SW, Glen Burnie, MD 21061  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart  Approximate Interval
Physician Medical	e av	failure. List only one cause on each line.
caminer		Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic cardiovascular disease Due to (or as a consequence of):
	F	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated
recuted and ransit		d.
00, e be exec ysician ar burial - t	<b>l</b> edical	X UNPENDED #1 as noted, 23a, PII,27, per ME, G895 9/17/09 TT
Records, P.O. Box 68760, The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial - transi	n/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year
Box 6876 e death certificate the attending phy	Physician/N	past 12 months?  4 Pregnant at time of death 5 Other (Specify)
D. Be the de	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
ords, P.O. w requires that to be seen signed by should be detact	d by	
of Vital Records, g Physician: The law require. the christicate has been sineral director, page 2 should be	Completed	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of
Reco The law cate has	Juo.	performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
ital Relician: The sertificate	Be	25. Was case referred to medical examiner? 25. Place of Death (Check only one)
S Division of Vital   Hospital or Attending Physician: 24 hours after death. Teles of The This certif lely filled in by the funeral director,	- To	28 Describe how injury occurred.
ion tendin eath.	ation	1 X Natural 5 Pending (Month, Day, Year) 1 Yes 2 No
Division tal or Attendi rs after death.	Certification:	3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Di To the Hospital within 24 hours a To the Funeral I		29d. Certified 4 Continue The rest of my knowledge death accurred at the time date and place and due to the cause(s) and manner as stated
To the II within 24 To the F	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
F 3 F 8	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
		Parkell Withall, MD O.C.M.E. August 2, 2009
7+1		30. Name and address of person who completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature
Regis	trar	AUG 0 4 2009 Deseur B. Granes

		F	Please				naelible in partment of			•	•	ible.	
	_	For State Registrar					ertificate o			, ,	. No. 2 (	009	24878
Physicia /Medica	n	1. Decedent's Name (Fir Fugere Wil		ast)						Date of Death Month	Day	Year 2.009	3. Time of Death 0543 14M
Examine		4a. Facility Name (If not	institution, gi		,	*	-	or Location of D		1	4c. Count	y of Death	
and the fact of		SINAI HOS			LTIM			MORE	CIT	Υ			
Funeral Director		5. Social Security Number 250–64–7900	)	Sex 1X M 2□F		yrs. last birthda 69 Yrs	Months   Day		/lin.	Date of Birth (Month, Day, 1) 3/04/194	_	9. Birthpi Coun	lace (State or Foreign try)
w	-	Usual Residence of Deci 10a. State 10b	edent . County		100	. City, Town or	Location					11	0d. Inside City Limits
Maryla f sho	0	MD	,			•	timore						1 TYes 2 No
r 28a	Director	10e. Street and Number					10f. Zip Code			10	g. Citizen of	What Coun	try?
th with		3714 Arca	dia Ave	nue				21215				USA	
tems ter mu	Funeral	11. Marital Status		12. Was Dec	orces?	in U.S. 1	Was Decedent of If Yes, specify Co	Hispanic Origin's uban, Mexican, P	? (Specification (Specification)	y Yes or No- an, etc.)		ce - America	
rs afte	by F	1 ☐ Never Married 3 ☐ Widowed 4 ☑		1 ☐ Yes If Yes, Gi Year or D	ve		1 □ Yes 2 ₩ N	o Specify:			Speci	∜: Blac	·k
2 hou	ted	15.	Decedent's E	ducation	41001		cedent's Usual Occ			1	6b. Kind of 8	Business/Inc	
thin 7; e. an ''n Medi	ple	(Specify of Elementary/Secondary		rade completed) College (	1-4or 5+)	(Gife	ive kind of work dor a. DO NOT use reti	red)	working	-			
filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Be Completed	12					Spot W			-		eneral.	Motors
ntal H ed otl	Be	17. Father's Name (First Charlie Wi		i)				18. Mother's	,	First, Middle, Ma	aiden Surna	me)	
should mark matic	ှ	19a. Informant's Name/l	Relationship	(Type, Print)		19b. Ma	ailing Address (Stre	et and Number o		tie Ross	City or Towi	n. State. Zin	Code)
alth ar 27 is r trau		Nickell Wild					421 Winches				•		
es 1 a of He of He r othe		20a. Method of Disposition				Ob. Place of Dis	sposition (Name of crematory or other p	lace)	Date	9 2	Oc. Location	- City or To	wn, State
Pag ment ant: It		4 Donation 5			State	Arbut	tus Cemeter	7 0	8/07/	2009	Ba	ltimore	Maryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral	I Service Lice	ensee			22. Name and Add	ress of Facility 1	Wylie andal	Funeral Istown. 1	Homes Yarvl <i>a</i> n	of Balt d 2113	imore County 33
		23a. Part1. Enter the dis shock, or heart fail	sease, or cor	nplications that	caused the cach line.	death. Do not							Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)				MIONS		HTED WI				LURE	Onset and Death
/Medical Examiner		resulting in death)	1	Due to	(or as a cor	sequence of):							
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xecuted and al-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	1	C									
		resulting in death) Last		Due to	(or as a cor	sequence of):							
	dical			d			<u> </u>						
death certifica attending pl	Physician/Medic	IF FEMALE: 23b. Was decedent preg	nant	23c. If yes, ou							23d. D	ate of delive	rv
death e atte	icia	in the past 12 mont	ths?	4□Preg	nant at time		3 □Ectopic pregnar 5 □ Other (specify)						Day Year
at the 1 by th stache	hys	9 Unknown		9□Unkn									
res tigne	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DIABETES MELLITUS							23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown				
law re	Completed	HYPERTE	-NS(0)	7						24a. Was an	24b		psy findings available
The lav	E 0									autopsy perform 1∐ Yes 2	ed? YNo	death?	mpletion of cause of 2□ No
ician: Th	Re	25. Was case referred to examiner?	o medical	Hospital:					Death (C	Check only one			
Phys rat dir	0	1 ☐ Yes 2 ☐ No 27. Manner of Death		Hospital: 1  28a. Date		2 ER/Outpat	IEIK JUDON			5 Residen		. , ,	)
ding th. After fune	tion		Pending investigation	(Mor	th, Day Yea		y W	ork? □Yes 2□No	200	a. Describe now	rinjury occu	irred	
Atter er dea ector by the	Certification:		Could not l	28e. Place	e of injury - / ing, etc. (Sp	At home, farm,	street, factory, offic	е	28f.	Location (Stre	et and Num	ber or Rura	l Route Number,
ital or ral Dir	- G								V.				
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifice completely filled in by the funeral director, for the funeral director.	Medical	29a. Certifier 1 (Check only one)	Certifying P Medical Exa	i <b>miner:</b> On the b	e best of my pasis of exame ner stated.	knowledge, de mination and/or	eath occurred at the r investigation, in m	time, date and p y opinion, death o	lace, and occurred	due to the cau at the time, da	ise(s) and n le and place	nanner as st , and due to	ated. the cause(s)
To the Comp	Ž	29b. Signature and title		2 /		h	1	nse number				ed (Month,	_
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In		30. Name and address of Aup En (1) 31. Date filed (Menth, Da	Per	PLES	MO Pagistrar's S	SINAL	HOSPITA	16 01-	BAC	TIMORE	<u> </u>		
State Registra	e r	AUG	0 4 20	09 De	www.	A. A	all						

matthew wallace Clinton Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-05925 State of Maryland / Department of Health and Mental Hygiene **UNK UNK** 2009 24879 Certificate of Death 1- For State Registrar

1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month Day July 28, 2009 1850 hrs Clinton Matthew Wallace **Medical Examine** 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number Anne Arundel Edgewater Near Muddy Creek Road 2 miles East of Mayo Beach 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 7. Age (in yrs. last birthday) 5. Social Security Number **Funeral** Foreign Country) Hours 216-84-4505 Directo 1 X M 08/25/1969 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 X Yes 2 No Baltimore M) 28a-f show s 23a or 28a-f show notified at once, death with the Maryland Director 10q. Citizen of What Country? 10f. Zip Code 10e Street and Number 21207 USA 3016 Wayne Avenue 14 Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1 X Never Married 2 Married 2 X No Specify: Black it. Pages I and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.
rtant: If item 27 is marked other than "natural". on If Yes, Give Year Yes 2X No specify: Widowed Divorced ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) marked other than' MD 21215-0036 12 Business Entertainment Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Deborah Canty Cephus Wallace Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address 19a. Informant's Name/Relationship (Type, Print ) 1226 Harwall Road, Gwynn Oak, Maryland 21207 Deborah Canty/Mother 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a, Method of Disposition Baltimore, crematory or other place) Cremation 3 Removal from State X Burial 2 Woodlawn Cemetery 08/05/2009 Woodlawn, Maryland Donation 5 Other Specify 22. Name and Address of Facility Wile Head Home of Baltimore County Signature o Fune al Service Licenses 9200 Liberty Road, Randallstown, Maryland 21133 Part I. Enter the disease, or compliant is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Physician /Medica Death Drowning Immediate Cause (Final disease vaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed ca tending physician a use as the burial -AMENDED UNPENDED Physician/Medi Records, P.O. Box 68760. 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 3b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Yes 2 ✓ No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available 24a. Was an peen prior to completion of cause of autopsy death? certificate has performed? 1 🗸 page, Yes 2 Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medica Division of Vital director, Be examiner? Residence 6 V Other: Scene Hospital:, ER/Outpatient 3 Nursing Home 5 Inpatient 2 ို 1 V Yes 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury 27. Manner of Death Subject drowned in river Certification: Jul 28, 2009 1850 hrs Natural Yes 2 V No Pending the 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State)
Near Muddy Creek Road 2 miles East of Ma, Edgewater, (Specify) River 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only Medical Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie July 29, 2009 O.C.M.E. Kall, MI

State Registrar e of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Pamela E. Southall, MD

31. Date filed (Month.

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month July 27 **Physician** 2009 Ruth Walker 10:00A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept. 6 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 □ F Months Days Hours Sept. 216-22-4135 81 1927 Maryland **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural" --- any injury or other traumatic events. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Maryland Anne Arundel West River 1 ☐Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5172 Chalk Point Road 20778 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo 14. Race - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No white If Yes, Give Year or Dates: Specify: <u>م</u> Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Auditor State of Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Wickard Louise Liebau ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walker Jr spouse Lawrence 5172 Chalk Point Rd. West River MD 20778 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 7/29/09 Baltimore Maryland Crematory 22. Name and Address of Facility Stallings Funeral Home P.A. 21. Signature of Funeral Service (ic nse 3111 Mountain Road Pasadena MD 21122 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or cor plica or schat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final SHUMMS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): I or Attending Physician: The law requires that the death certificate be executed after death. attending physician and for use as the burial-transit Exami resulting in death) Last Due to (or as a consequence of): P.O. Box 68760≿ Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Year Day 5 ☐ Other (specify) 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Yo 24a. Was an s certificate has I lirector, page 2 s autopsy performe 1 ☐Yes 2 No To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital 1 Yes 2 No. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 pupatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier hactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Description Herical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature of certifie 30. Name and address 6 31. Date filed (Month, Day, Year State 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Jeanne Rose Warns 2009 9:03 A<sup>M</sup> 27 Ju<sub>1</sub>y 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Co. Rosedale Franklin Square Hospital 8. Date of Birth (Month, Day, Year) Nov. 22,1929 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Hours Months Days Min. 1 □ M 2 KF 79 Yrs 214-24-9561 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 🛣 No Middle River Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21220 United States 3530 Buckboard Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 □Yes 247XNo 1 ☐ Never Married 2 X Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Trucking Company Administrative Assistant 9 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alveria Peacock Arthur Beatty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 9509 Kingscroft Terrace Apt. R Perry Hall, MD 21128 Barbara Granger (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 7/31/2009 Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Fut ral Servi Me 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) > 5 Years Coronary Artery Disease Due to (or as a consequence of) > 5 Years <u> Arteriosclerotic Cariovascular Disease</u> Sequentially list conditions Due to (or as a consequence of >10 Years Hypertension Due to (or as a consequence of): Diabetes Mellitus Type 2 710 Years 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Renal Insufficiency 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an

**Physician** /Medical Examiner

permit. Pages 1 and 2 should be filed 1 Department of Health and Mental Hygin Important: If item 27 is marked other 1 any Injury or other traumatic event, II

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

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**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be rigitled at

hours after

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Maryland 21215-0036

Baltimore,

sician and burial-trans attending physician for use as the buria sed by the a signed by cate has been signal page 2 should b director. this funeral After 1 nours after death.

neral Director: Af

filled in by the fur

law requires that the death certificate be executed

Hospital or Attending Physician: The

24 hours a

within 2 the

Box 68760,

P.0.

Records,

Division of Vital

Examine Physician/Medical 2 Completed Be Certification: To

Se puentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last in the past 12 months? 9 Unknown 1 Tes 2√ No

23b. Was decedent pregnant Hyperlipemia

25. Was case referred to medical examiner? Hospital: 27. Manner of Death 5 Pending investigation 1X Natural

2 Accident 6 ☐ Could not be 3 Suicide 4 Homicide

28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work?

1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

performed? 1 □Yes 2 XNo

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOO 28812

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes 2 ☐ No

and manner stated.

Vincent A. DiPietro, M.D. 7801 York Road Suite 102 Baltimore, Maryland

State Registrar

ca

29a. Certifier

(Check only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year) 32. Pegistrar's Signature



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 23:20 July 2009 28, /Medical Williams Johnnie 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Montgomery 9. Birthplace (State or Foreign Washington Adventist Hospital TUTTAKOMA URAZIKIS. **Funeral** Months Days Hours 1 ☑ M 2 □ F 1-6-1951 58 Director 260-80-1104 Georgia Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Prince George Hyattsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" page. U.S.A. Funeral 402 Chillum Rd #301 20783 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Yes 2 □ No 14. Race - American Indian, Black, White, etc. Y Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify Specify: 2 Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) A.M. Briggs Meat Co. 12th grade Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willie Mae Williams James Williams ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ella J. Boyd-Williams (Wife) 402 Chillum Rd. #301 Hyattsville, Md. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Ouantico Nat. Cemetery 8/4/2009 Triangle, Va. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home, Inc. 4217 9th Street, N.W. Washington, D.C.20011 23a. Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HRUNT Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of): he law requires that the death certificate be executed attending physician and for use as the burial-transit UEMOTHURA Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, OBACCO Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) his certificate has been signed by the director, page 2 should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2) 1 Yes 1 **I**npatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 > ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated.

7600 CARROLL Registrar's Signati 31. Date filed (Mo.

29b. Signature and title of certifie

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of de in (Item 23a) (Type, Print)

AUG TAKOMA MD

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1- For Amend Items State of Mayland /29	Certificate of Death		
Physic	ian	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 6:21 AM M
/Medi		Ronald James Wolfe  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of D		4c. County of Death
Exami	ner	2207 Byrnes Court #C	Bel Air		Harford
Funeral		Social Security Number	nday) If Under 1 Year If Under 24	Hrs. 8. Date of Birth (Month, Day,	
Director		213-44-9421 <sup>1</sup> ∑M 2□F 64 Y	rs. Months Days Hours A	May 23,	1945 Pennsylvania
		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
hov 1	7	10a. State			1 Tes 2 No
280-f	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?
0 0	늄	2207 Byrnes Court #C	21014	10	
70 23 True	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Pr	? (Specify Yes or No-	USA 14. Race - American Indian,
r to	F	1 Never Married 2 Married Armed Forces?  1 Never Married 2 Married Forces?  1 Yes, Give		uerto Rican, etc.)	Black, White, etc.
Fred.	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 166-69	1 ☐ Yes 2 No Specify:		Specify: White
ital Hygiene.  And Cher than "neture!", or iteme 23a or 28e-f ehow event, the Medical Exeminar most be notified at	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of	working 1	6b. Kind of Business/Industry
9 2	nple	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)		
ygier traff	Co	12 1	paper delivery	<del></del>	distribution
d oth	Be	17. Father's Name (First, Middle, Last)  John Jacob Wolfe		Name (First, Middle, M.	
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n and 7 ie n			Mailing Address (Street and Number of 207 Byrnes Court #		•
Heelt ther			Disposition (Name of		Oc. Location - City or Town, State
penint. Tays 1 saids should be many mind to be said to be such that the many part beganded to Heelth and Mental Hydione. Important: if them 27 is marked other than "neturel; or iteme 28 or 28e-f show any injury or other traumatic event, the Medical Engalizer must be notified at 2006.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemeters	v, crematory or other place)		,,
ntani njury		4 Donation 5 Other (Specify)	22 Name and Address of Facility		
Dep P		21. Signature of Euneral Septice Licensee RestarId S. Wady, philector	State Anatomy Boa		Baltimore Street
		23a. Part Enter the disease, or complications that caused the death. Do n	Baltimore, MD 21 ot enter the mode of dying, such as car		st, Approximate
		shock or heart failure. List only one cause on each line. Immediate Cause (Final			Interval Between Onset and Death
hysician /Medical		disease or condition resulting in death)  a. Due to (ocus a consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequenc	Heart Fall	UIE	Unhnow
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4 - 0	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home, far		28f. Location (Str	eet and Number or Rural Route Number,
octo	Certification:	4 Homicide determined building, etc. (Specify)		City or Town,	, State)
after de	aic	29a. Certifier	, death occurred at the time, date and p	lace, and due to the car	use(s) and manner as stated.
nerel Directo	0	(Check only one)  2 Medical Examinar: On the basis of examination and and manner stated.	Vor investigation, in my opinion, death of	occurred at the time, da	te and place, and due to the cause(s)
n 24 hours after de	D	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month, Day, Year)
within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical				_ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
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within 24 hours after de To the Funeral Directo completely filled in by th	Med	30. Name and address of person who completed cause of death (Item 23a) (	51050 (M	10) [	July 21, 2009
within 24 hours after de To the Funeral Directo completely filled in by th	Med	30. Name and address of person who completed cause of death (Item 23a) ( Elene Sem 205, M.D., VR Mor	51050 (M Type, Print) Cyland Neath Ca	ne. System	n, Perry Point, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 11 tems 10b-f per inf 2895 9-17-09 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 **Physician** STANLEY WAGNER JŰĽŸ 11:50A <sup>™</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BRIGHTON GARDENS ROCKVILLE **MONTGOMERY** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Nonths | Days | Hours | Min. | 02/19/19/1914 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 95 086-09-7991 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location r items 23a or 28a-f shov MD TATYES 2K No Montgomery BALTIMURE Rockville Funeral Director 10g. Citizen of What Country? 10e. Street and Number 5550 Tuckerman Lane Apt. 10f. Zip Code 20852 21215 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If ¶as, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify Completed by Specify: WHITE 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry The Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ than Elementary/Secondary (0-12) EDUCATION GUIDANCE COUNSELOR permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 Is marked other any injury or other traumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **PAULINE** FORTGANG EDWARD WAGNER ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6410 RIDGE DRIVE, BETHESDA, MD 20816 IRA WAGNER/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW CONG 08/02/2009 REISTERSTOWN, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Funeral Service Liner 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that existed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) PULMONARY FIBROSIS Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) 1 TYPS 2 No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by CORONARY ATHEROSCLEROSIS 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☑No 1 ☐Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Matural 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only within 2 and manner stated. To the 29c. License number 29b. Signature and title of certified D26259 30. Name and address of person who completed cause of AVA KAUFMAN, MD 8218 WISCONSIN AVE., completed cause of death (Item 23a) (Type, Print) BETHESDA, MD

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

AHG 0 4 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month August 2, 2009 1715 hrs Scott Justin Yeagy Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore County** Porter Beach & Back River 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Country Months Days Hours Min Director August 18,1982 Maryland 2 1 X M 26 214-13-9086 Usual Residence of Decedent ì 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Yes 2 X No Parkville Balto. 1. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygene, retart: If tene 27 is marked other than "natural", or items 23a or 28a-f shor or other traumatic event, the Medical Examiner must be notified at once. Md. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21234 9734 Red Clover Ct. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? White, etc. 1 X Never Married 2 Married 2 X No Yes Specify: White 2 X No specify: Divorced Yes, Give Yea Yes Widowed ð 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+ MD 21215-0036 Tide Water Engineering Communications Inspector 4 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Janie Dawson William A. Yeagy

19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Parkville, Md. 21234 9734 Red Clover Ct. William A. Yeagy III 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 8-7-2009 Parkville, Md. Parkwood Donation 5 Other Specify Signature of Funeral Servic License 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham. Md. 21236 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Head Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Discase or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician and the burial - trans Physician/Medical UNPENDED AMENDED Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Day Year Live birth 3 Ectopic pregnancy Fetal death Pregnant at time of death Other (Specify) law requires that the death Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 Yes 2 ✔ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? The ✓ Yes 2 ✓ Yes 2 certificate No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certiff completely filled in by the funeral director. 25. Was case referred to medical 26.Place of Death (Check only one) æ examiner? Hospital: 1 Other<sub>4</sub> Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 1 Yes 28a. Date of Injury FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject struck by boat **FOUND** Natura 1 Yes 2 ✔ No Pendina Director: Aug 2, 2009 1707 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) Porter Beach & Back River , Essex , MD (Specify) River Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) опе) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier August 3, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 **OCME 2006** 

State Registra 31. Date filed (Month, Day, Ye

32. Raistrar s Signature

ORIĞINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. / 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) <sup>D</sup>2<sup>y</sup>009 Month Year **Physician** 27 4:45 PM Russell J. Yarborough, Sr /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 1102 Druid Hill Avenue Apt.209 Baltimore N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 3-1-1940) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Year) Hours Months Days 238-60-5129 69 N.C. Director Usual Residence of Decedent the Maryland 10b. County 10c, City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 1X Yes 2 □ No Director MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hyglene. antif item 27 Is marked other than "natural", or items 23a or Juy or other traumatic event, Ite Medical Expositive ment for 21217 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \_\_Yes \_ 2 M\_No If Yes, Give Year or Dates: S 1102 Druid Hill 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Specify: Black þ 3 ☐ Widowed 4 🎇 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) llth grade Disabled Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Russell G. Yarborough Annie Mae Yarborough ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 912 N. Streeper Street Balto, MD 21205 <u> Martha Brunson-Daughter</u> Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or once. Trinity Cemetery 8-4-2009 4 □ Donation 5 □ Other (Specify) Balto, MD FUNERAL HOME-EAST Balto, MD 21202 22. Name and Address of Facility MARCH 21. Signature of Funeral Service Licensee 1101 E. North Avenue B won 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequency off Examir Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 ☐No 124 hours after death.
Puneral Director: After this certificate has been signed by the letely filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performer 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only o e Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Seath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ∠ □ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 hou To the Funel completely file 29a. Certifier Medical and manner stated.

State Registrar 29b. Signature and title of certifie

Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Year)

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Anna Margaret Zapf 29, /Medical 2009 JuJv4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 306 Oakwood Road Dunda1k Baltimore

9. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year Months Days If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 □ M 2 🗓 F 212-42-2215 Director 65 Maryland Dec. 11, 1943 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, tra Medical Evantiner ruust tea multifad al Director Maryland 1 ☐ Yes 2 X No Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death v Hygiene. ither than "natural", or items 23s Funeral 306 Oakwood Road 21222 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Armed Force 1 ☐Yes 2X No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2X No Specify 2 White 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary 12 years Clerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles E. Bell Helen K. Barron 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sl Health an em 27 is r permit. Pages 1 and 2 Department of Health Important: If Item 27 any injury or other tr Robert P. Zapf, Jr. (Husband) 306 Oakwood Road Dundalk, Maryland 21222 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakeview Cemetery 8/3/2009 Sykesville, Maryland 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licensee 7922 Wise Avenue Dundalk, Maryland 21222 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line ediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TNEEN **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it as a sequentially list conditions, it as a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1, Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe certificate 2 No 1 □ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After th funeral 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only and manner stated.

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State Registrar

31. Date filed (Month, Day, Year)

and title of certific

Name and address of person, who completed cause of death (Item 23a) (Type, Print) HI LOOK (IKI) NA 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 1148 M 4 Y ron 10900 8005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gen DIne Mon monleamer No 510 9. Sirthplace (State or Fpreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 M 2 □ F 58 274-62-0708 Gurana Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10a. State d other than "natural", or items 23a or 28a-f show event, the Medical Evenine must be notified at 1XYes 2 No Director Silver mol. Montgomery 10g. Citizen of What Country? 10e. Street and Numbe Guyana Piney Branch Rd. Completed by Funeral filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Indoguyanese If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Data Transformation nd Mental Hygiene. marked other than " College (1-4or 5+) Elementary/Secondary (0-12) Financial Analyst COTP. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Mental Important: If item 27 is marked o any Injury or other traumatic eve Pages 1 and 2 should be Goodasaul Subhan ursula ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BenneTT (Sister Fazia 35 High ST. STaveley Chesterfield, UK, 8433uu 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Riverdale, md. Chambers Crematory July 23, 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chambers Funeral Home + M670 5801 Cleveland Ave. Riverdale Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ATHEROSCLEROTIL CARDIOVASULAr SUDDEN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) 09 Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 | No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy this certificate 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 2 2009 cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed HERRING 18/01 31. Date filed (Month, Day, Year) State

Registrar

21

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 16° 2009 Year 1545 М Buelvas July Rafael Pedro 4c. County of Death Montgomery 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3 / 20 / 1920 9. Birthplace (State or Foreign 5. Social Security Number Days Hours Months 1⊠ M 2□ F 89 214-43-8345 Colombia Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State Montgomery Kensington 1 ☐ Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Colombia 20895 10920 Connecticut Ave. #502 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Colombian 1 Yes 2 No White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Farmer 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Josefa Rodriquez Pedro Rafael Buelvas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1989 10920 Connecticut Ave.#502 Kensington, Md 19a. Informant's Name/Relationship (Type. Print) Ofelia Rojas/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Bernoval from State 7/20/2009 Beltsville, Md Chesapeake Crem 5 ☐ Other (Specify) 4 Donation PHILIPADOS RINALDI FUNERAL SERVICE, P.A. 9241 Columbia bLvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Arterioscleratic Cardiovascular Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (of as a consequence or) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year

**Physician** /Medical Examiner

Department of Health ar Important: If item 27 is any injury or other trau

Pages 1 and 2

**Physician** 

/Medical

Examiner

MD

Director

Funeral

2

Completed

**Funeral** 

Director

? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Experience must be notified at

2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or iten

Baltimore, Maryland 21215-0036

death with

Examiner attending physician and for use as the burial-transit Physician/Medical certificate has been signed by the rector, page 2 should be detached 2 Completed : After this certifical funeral director, p Be Certification: To e Hospital or Attendi 24 hours after death. e Funeral Director: A eletely filled in by the fu

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE:

> 4 Pregnant at time of death 5 Other (specify)

7/16/09

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy 1 □Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 2 No

25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 □Yes 2 □ No

2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rober

8600 Old Georgetown Rd Bethesda

State Registrar

Medical

othstein mo 31. Date filed (Month, Day, Year) 3. Registrar's Signature 21

To the within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygien (1) State Registrar 7/20/09 AACO HEALTH CMHCertificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 1310 M 2009 Irene Brown July MURY 4c. County of Death 4b. City. Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Rehabilitation Anne Avundel vofton And Corre If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Days Hours Min. 1 □ M XXF 212-56-2390 10/6/1931 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 🛠 🔀 No MD Anne Arundel Severn 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8573 Pioneer Dr. 21144 USA 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Black 1 ☐ Yes 2 No Specify: Specify: 3 Vidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Wilkerson Narion Wilkerson Marion Wilerson Annie Creek 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8573 Pioneer Dr. Severn, MD 21144 Mary Simms Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 7/18/2009 Atlantic Crematory Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licenses 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lift only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final I tha stuge dementia disease or condition resulting in death) Due to (or as a consequence of): oronaky Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Diabetes resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2₽ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

death certificate be executed o <u>م</u> Division of Vital Records,

**Physician** 

/Medical

**Examiner** 

Director

Funeral

Completed by

**Funeral** 

Director

or than "natural", or Items 23e or 28e-f show the Medical Examiner was be notified at

other

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is rr any injury or other traum. 2002.

**Physician** 

/Medical

Examiner

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attending p

signed by the a

Examiner

Physician/Medical

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Certification;

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

and Mental

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

certificate t funeral director this After or Attending within 24 hours after death. To the Funerel Director: A the filled in by

State Registrar

July 14, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Elkridge MD 32. Registrar's Signature 31. Date filed (Month Elever S. park

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

R146251

and manner stated.

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/Medic		4a. Facility Name (If not institution, give				4b. City	, Town, or	Location of Death	July		County of De	1	.00 /1
Examin	er	Sina: Hospital	_				•	imore			N/A		
Funeral		5. Social Security Number 6. S	ex 7. Age	e (In yrs.	last birthday	) If Unde	r 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	ay, Year)		Country)	ate or Foreign
Director		217-92-72-40	<b>∑</b> M 2□F	4	7 Yrs.				Aug 1	6 19	961 D	. C.	
and wo		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or L	ocation						10d. Insid	de City Limits
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er de	Funeral	11. Marital Status 1 □XVever Married 2 □ Married	12. Was Decedent I Armed Forces? 1 Yes 2 X		S.   13.	. Was Dec	ecify Cuba	lispanic Origin? (S an, Mexican, Puert	o Rican, etc.)	0-	Black, Wh		111,
urs aff	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	10		1 🗆 Yes	X No	Specify:			Specify: P	Black	
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d be de lental ked o	To Be	Samuel P. Boste						Alice	V. Tu	rner	•		
shoul and Mark mark	F	19a. Informant's Name/Relationship (			19b. Mai	ling Addres	s (Street	and Number or Ru				, Zip Code)	
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pormit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at other.		21. Signature of Funeral Service Licer		_				<sup>알 of &amp;acili</sup> Son St. An					
A6D N		Zarry A. Keo 23a. Part1. Enter the disease, or com	plications that caused	the deat	-						IG . 21	Approx	ximate al Between
Physician		shock, or heart failure. List only Immediate Cause (Final			01		61						and Death
/Medical		disease or condition resulting in death)	aDue to (or as	a conseq	uence of):	onary	Zdev	~4					
Examiner	,	Sequentially list conditions.	b										
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ath cell tendir	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth	2 Feta	al death 3	Ectopic		y			23d. Date of o	delivery Day	Year
the at hed for	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of o	leath 5	Other (	specify)						
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after data l Direct	Certification:	4 ☐ Hornicide determined	building, ef	ic. (Speci	fy)		,		City or T	òwn, State	9)		,
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director,			nysician: To the best miner: On the basis of										susp(s)
the Hin 24 the Fi	Medical	one)	and manner st										
vit vit	2	29b. Signature and title of certifier	5			2		se number			te signed (Mo	_	ear)
		30. Name and address of person who	completed cause of	-	△.	e Print)	۵ 5	59062		_Ju	17 14,	2009	
C112							dere	Ave. R	altimace	MA	21215	-	
Sta	ate	31. Date filed (Month, Day, Year)	32. Registi	rar's Sign	ature	1			Sad & L C	.,~			
Regist	rar	JUL 17	CUUY DENS	un	Ø. x	park							

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2009 Edna Eloise July 19, 7:00 PM **Physician** Brophy /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Villa Rosa Nursing Home Prince George's Mitchellville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Yea March 24, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Months Days Hours Min 1 □ M 2 🔀 F 94 Wash. 578-22-4691 1915 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, it is Medical Evanting I must be netified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2000 No **Funeral Director** MD Prince George's Mitchellville 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20721 USA 3800 Lottsford Vista Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ∐Yes 2**½** No Specify þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grace E. Helvestine Raymond Earl Taylor ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Edward J. Brophy, Jr (son) 1921 Manning Circle Dunkirk, MD 20754 permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)  $\mathrm{Jul}^{\mathrm{Pate}}_{\mathrm{V}}$  24 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemeterv 4 ☐ Donation 5 ☐ Other (Specify) 2009 Brentwood, MD 22. Name and Address of Facility Lee Funeral Home Calvert, PA 21. Signature of Juneral Service License Gary J. 20736 Owings, MD 8125 Southern Maryland Blvd. 23a. Part (Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 1-Par disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Box 68760, physician the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Pregnant at time of death 5 Other (specify) o s been signed by the should be detached 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has birector, page 2 sl autopsy performed: 2 No 1 ☐Yes 2 ☐No 1 □Yes Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certificaletely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury a¥ Work? 28d. Describe how injury occurred 27. Manper of Death 1- Natural 2 ☐ Accident 5 Pending 1 □Yes 2 □ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Combined Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one and manner stated To the I within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifies 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14300 Gallant Fox Road Ste 222 Bowie, MD MDRakesh Arora, 31. Date filed (Month, Day, Year) 32. Registrars Signature State

DHMH 17 Rev 1/2001

Registrar

09-05834 Linda Ann Buchberger

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 24893

	F	Registrar	rtificate of Death	Reg	
Physicia	n/	Decedent's Name (First, Middle,Last)		Date of Death     Month     I	3. Time of Death
edical Examin		Linda Ann Buchberger  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location	July 26, 200	4c. County of Death
		2915 Bidle Road	Middletown	<b>.</b>	Frederick
Funeral	7	5. Social Security Number 6. Sex 7. Age (In yrs.			(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director	-	256-90-3531 <sub>1 M 2</sub> 55	Yrs. Months Days Hour	s Min. 6/15/	/1954 Country)CO
	-	Usual Residence of Decedent			10d. Inside City Limits
w any	١	10a. State 10b. County 10c. City MD Frederick	Middletown		1 Yes 2 X No
Aaryland 28a-f show 1 at once.	흱	10e. Street and Number	10f. Zip Code	100	. Citizen of What Country?
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shomatic event, the Medical Examiner must be notified at once.	Director	2915 Bidle Rd.	21769		USA
with the ns 23a		11. Marital Status 12. Was Decedent Ever in U	J.S. 13. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica	igin? ( Specify Yes or No-	14. Race - American Indian, Black, White, etc.
death or iten	Funeral	1 Never Married 2 X Married Armed Forces?  1 Yes 2X No			
s after ral",	à	Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)	1 Yes 2X No specify  16a. Decedent's Usual Occupation (Give		Specify: White  16b. Kind of Business/Industry
2 hour "natu	ted	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NO		
D36 thin 72 ne. than "	Completed	4	homemaker		own home
5-0036 iled within 7 Hygiene.		17. Father's Name (First, Middle, Last)		er's Name (First, Middle, M	
21215-0036 Duld be filed within 7: I Mental Hygiene. I marked other than ic event, the Medical	Be	Jacob Benjamin Liebelt  19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Nu	n Grace Sat	DY Der. City or Town, State, Zip Code)
MD 2 d 2 shou lth and M n 27 is n	ပ	Paul Buchberger (Husband)	2915 Bidle Rd.		
e, N 1 and 1 and Health item	i	20a. Method of Disposition  1 Surial 2X Cremation 3 Removal from State	Place of Disposition (Name of cemetery, rama toryace) mithsburg	Date	20c. Location - City or Town, State
MOT Pages ent of aut: It		4 Conation 5 Other Specify:	Smithsburg	8/1/2009	Smithsburg, MD
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med	1	ignatur of Funeral Cervice Licensee	Dona 1 d B. POB 18, Mic	hompson Fi	meral Home
Physician		Sa. Part I. Enter the disease, or complications that caused the deal	th. Do not enter the mode of dying, such as	cardiac or respiratory arre	st, shock, or heart Approximate Interval
/Medical		failure. List only one cause on each line.	and alcohol intoxica		Between Onset and Death
taminer		Immediate Cause (Final disease or condition resulting in death)  a. HYGIOXYZINE a. Due to (or as a consequence)			
	<u>.</u>	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence	of);		
	Examiner	(Disease or injury that initiated			
red Insit	Exa	events resulting in death) Last Due to (or as a consequence			
760, Ticate be executed g physician and the burial - transit	ical	X UNPENDEDAMENDED 23a,2/,	,28a-f,perME g894 8/	10/09 TT	
760, Treate be g physic the burn	Medical	IF FEMALE: 23c. If yes, outcome of pre	egnancy		23d. Date of delivery  Month Day Year
Box 687 ne death certific the attending	sician	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ecto	pic pregnancy	Month Day Year
Box s death c the atten	ysic	1 Yes 2 No 9 Unknown g Unknown			
d by	by Phy	Part II. Other significant conditions contributing to death but no	t resulting in the underlying cause given in		bacco use contribute to the cause of death?  2 No 3 Probably 4 V Unknown
S, P. uires th				[ 24a. Was a	
ords, aw requir as been s	Completed			autop:	sy prior to completion of cause of med? death?
ial Rec ian: The l certificate b	Con		00 Pi (0	1 ✔ Yes	2 No 1 Yes 2 No
f Vital Rec Physician: The ler er this certificate leral director, page	Be	25. Was case referred to medical examiner?	ER/Outpatient 3 DOA Other:	th (Check only one)  Nursing Home 5	Residence 6 🗸 Other: Scene
1 of Vital Records, Ling Physician: The law requir After this certificate has been s funeral director, page 2 should I	. To	27. Manner of Death 28a. Date of Injury	28b. Time of Injury 28c. Injury at W		now injury occurred
	ition	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation Fd 7/26/09	unk 1 Yes 2		
Division  To the Hospital or Attendit within 24 hours after death. To the Funeral Director: \( \)	Certification:	3 Suicide 6 X Could not be 28e. Place of Injury - At	home, farm, street, factory, office building,	etc. 28f. Location (S or Town, S	Street and Number or Rural Route Number, City state) 2915 Bidle Rd
Div Hospital or 24 hours afte Funeral Dit		29a. Certifier	edge, death occurred at the time, date and		town, MD e(s) and manner as stated.
the H thin 24 the F mplete	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	and/or investigation, in my opinion, death	occurred at the time, date	and place, and due to the cause(s)
T W T	Me	29b Sharature and title of pertifier	29c. License numb	er	29d. Date signed (Month, Day, Year)
		( Agon Corlection)	O.C.M.E.		July 27, 2009
		30. Name and address of person who completed cause of death (It		MD 21201	
		Laron Locke MD. Assistant Medical Examine  31. Date filed (Month. Day, Year) 37 Registrar's Sign	otivo a	IVID Z IZUI	
St Regis		AUG 0 / 9000 /2	D. Sparked		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day MARY LOUISE CLARK 9:44 p<sup>M</sup> JULY 27 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Chester River Manor Chestertown Kent 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Months Days Hours 218-09-5612 90 Nov 8 1918 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1X Yes 2 □ No Kent Betterton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 Bayside Blvd. 21610 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 2X No 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: White Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lab Technocian Chemical Company 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James William Clark Mary Elizabeth Toulson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Sorge (daughter) Betterton, MD. 21610 P.O. Box 64 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) 4 ☐ Donation Still Pond Cemetery 8/2/09 Still Pond, MD. 22. Name and Address of Facility
Galena Funeral Home of Stephen L. Schaech eral Service License 21. Signati M00510 23a. Fast. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.

Immediate Caise (Final disease or condition resulting in death)

a. Horric Charter Pulmarin Canada Comparing Conditions and Condition resulting in death) 118 West Cross St. Galena, MD. Approximate Interval Between Onset and Death 5eus( 0 4 Cars Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of, Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

and

physician

attending p

To the HospItal or Attending Physician: The law requires that the death certificate be executed

certificate

this c

Director: After th

within 24 hours aft

To the Funeral Di

completely filled in

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2

Certification:

Medical

Division or Vital Records, P.O. Box 68760.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

Completed by

Be

2

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ite

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If Item 27 is marked other that any lipury or other traumatic event, the once.

Baltimore, Maryland 21215-0036

death with the Maryland

Examine Physician/Medical IF FEMALE þ Completed

24a. Was an autopsy Yes 2 No 10 26. Place of Death Check onl one

24b. Were autopsy findings available prior to completion of cause of death? 2 No

25. Was case referred to medical examiner? 1 Yes 2 1 No 27. Manner of Death 1 Natural
2 Accident

3☐ Suicide

29a. Certifier

4 Homicide

5 Pending investigation 6 □ Could not be

determined

Hospital:

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Vursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number 7036 29d. Date signed (Month, Day, Year) 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan K. Ross, 516 Washington Ave. Chestertown, MD. 21620 M.D.

and manner stated.

State Registrar

31. Date filed (Month, Day, Year) AUG U4 32. Registrar's Signature

09-05442 UNK UNK Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

K UNK	1	State of Maryland / Department of For State Certificate of	Health and Mental Hygie Death	ne Reg. No. 2009 24895
Physicia	R	Registrar  1. Decedent's Name (First, Middle,Last)	2. D	ate of Death 3. Time of Death
dical Exami	ner	Sirian D. Cruz	Jü	onth Day Year 1112 hrs ly 11, 2009
		4a. Facility Name (if not institution, give street and harrise)	4b. City, Town, or Location of Death  Hvattsville	Prince George's
		2217 University Blvd. # 203  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		Date of Birth (MM/DD/YYYYY) 9. Birthplace (State or
Funeral Director		578-31-5203 1 M 2 X F 44 Yr	Months Days Hours Min.	6/20/1965 Foreign Honduras Country)
		Usual Residence of Decedent	lion .	10d. Inside City Limits
w any		MD Prince George's Hyatts		1 Yes 2 XNo
yland -f sho	į	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
215-0036  be filed within 72 hours after death with the Maryland hygiene.  Hygiene.  rked other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at once.	Director	2217 University Blvd. #203	20783	Honduras
with the ns 23a be noti		11. Marital Status	as Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rica	in. etc.)
death or iter	Funeral	1 X Never Married 2 Married 1 Yes 2 X No	Honduran Yes 2 No specify:	White Specify:
rs after ural", miner	<u>S</u>	or Dates:	ent's Usual Occupation (Give kind of work most of working life. DO NOT use retired)	done 16b. Kind of Business/Industry
72 hou a "nat	Completed	during	nemaker	Own Home
036 vithin ene. er tha	m d			st, Middle, Maiden Surname)
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than numatic event, the Medica	Be Cc	17. Father's Name (First, Middle, Last) unknown	Evelia	Acosta
212 212 ould be Ment: mark	일	19a. Informant's Name (Catherine (Cype) (Cype)		Route Number, City or Town, State, Zip 2009 40
MD 21 d 2 should th and Me n 27 is ma				ve College Park, Md ate 20c. Location - City or Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiest Important: I Hean 21 is marked other than "natural", injury or other traumaric event, the Medical Examinez.		20a. Wethod of Disposition 2 Permoval from State crematory or	other place)	/2009 Silver Spring,Md
Baltimore, permit. Pages I at Department of He Important: If the injury or other tr				
Bal permi Depa Impo injur		Nuk Drink	241 Columbia Bl	FUNERAL SERVICE, P.A. vd.Silver Spring, Md2091
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	r the mode of dying, such as cardiac or re	Between Onset and Death
Medica amine		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):		
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	iner			
B - =	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
be executed sician and until - transit	dical E			
30, te be ex sysician	ed			23d. Date of delivery
Box 68760, e death certificate be the attending physici	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 pregnant at time of death 5	Fetal death 3 Ectopic pregnance	cy Month Day Year
Box (e death of the attended for use	Vsici	1 Yes 2 No 9 V Unknown Pregnant at time of death 5 Unknown	Other (Specify)	Warrang of Hooth?
ords, P.O. B w requires that the d us been signed by the			ne underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 ✔ No 3 Probably 4 Unknown
s, P.O. irres that the signed by	Completed by			24a Was an 24b. Were autopsy findings available
cords law requents been	nolet			autopsy performed? death?
Rec The la			26 Place of Death (Check or	Tes 2 10 1 10 10
ital Recipionists	2 4	25. Was case referred to medical examiner? Hospital: 1 inpatient 2 ER/Outpa	Other:	Home 5 Residence 6 ✔ Other: Scene
n of Vital Records, ding Physician: The law require After this certificate has been a	8 F	1 ✓ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) (Month, Day Year)	, , , , , , , , , , , , , , , , , , ,	28d. Describe how injury occurred /ictim of chopping and cutting wounds
ion (tendin eath.		Natural 5 Pending Investigation	1 Yes 2 V No	28f. Location (Street and Number or Rural Route Number, City
Division tal or Attendinus after death.	Cortification.	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Multi-Family Apt.		or Town, State) 2217 University Blvd.# 203, Hyattsville, Md.
Ospital hours			occurred at the time, date and place, and	due to the cause(s) and manner as stated.
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate! within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys.	mplete	(Check only one)  2  Medical Examiner: On the basis of examination and/or investance and manner stated.  29b. Signature and title of certifier	stigation, in my opinion, death occurred at	the time, date and place, and due to the second
To To	00	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)  July 12, 2009
		W_W	O.C.M.E.	July 12, 2000
		30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner	111 Penn Street, Baltimore, MI	21201
	Stat	Donina IVI. Vincenta, IVID	all.	
Doc	اstra istra	te 31. Date filed (Month, Day Year) 2009 32 Registrar's Signature	Work.	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Day 2009 **Physician** Chu July 18, 8:30 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 209 Grange Hall Drive Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea June 26, 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex Funeral 7. Age (In vrs. last birthday) Year) Months Days Hours Min. 1 ★M 2 □ F 185-62-1404 94 Director 1915 Vietnam Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and terms 23a or 28a-f show int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location event, the Madigal Examinar must be notified at 1 ☐ Yes 2X No Directo Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 209 Grange Hall Drive 20877 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes ※XXNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify. Completed by Asian Specify: 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) \$upervisor Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Do V. Chu Lieu Thi Le ပ or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oanh C. Mudd/Daughter 209 Grange Hall Drive, Gaithersburg, MD 20877 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State July 2009 21 Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee lins Funeral Home Blvd. W., Silver Francis J. Coll 500 University Inc. Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Dementia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Unsease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ∐Yes 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Kesidence 6 Other (Specify) 1 ☐ Yes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1/165 Stratfield Court, 1st Ndidi Feinberg, MD Floor, Marriotsville, MD 21104

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

21

P.O.

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day **Physician** 1:25 a M 2009 Ying-Nan Chiu July 18 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 6. Sex **Funeral** Days Months Hours 1 X M 2 □ F 048-32-3817 75 Director November 25,1933 China Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show other traumatic event, the Musical Examiner noust be notified at 1 ☐ Yes 2 X No Director Silver Spring Maryland Montgomery the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ filed within 72 hours after death with 23a 712 Symphony Woods Drive 20901 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 🗷 No Specify. 2 Specify 3 Widowed 4 Divorced 'natural", Asian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) University 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Nian-Tai Chiu ဥ Yun-Dan Liang 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lue-Yung Chiu - Wife 712 Symphony Woods Drive, Silver Spring, Maryland 20901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory + 07/21/2009 Brentwood, Maryland Fun III Se vice 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Cardiopulmonary Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Respiratory Failure Sequentially list conditions, if any leading to immediate Due to (or as a consequence of) cause (Disease or injury that initiated events resulting in death) Last physician and s the burial-transit Exami Pneumonia Due to (or as a consequence of) Box 68760 The law requires that the death certificate be Physician/Medical Advanced Dementia attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) Ö ☐Yes 2☐No detached 9 Unknown 9 Unknown ρλ ۵, signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 X Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate 2 🗷 No 1 ☐ Yes 2 □No 1 □Yes funeral director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 
Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 X No ည 1 ☐ Yes this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After t Certification: 28d. Describe how injury occurred Attending Injury 1 X Natural 5 Pendina s after death.

I Director: After in by the fur investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Ь filled in within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) ၉ D0065069 July 20, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sirak Lemma, M.D., 1500 Forest Glen Road, Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** LIZABENT RUWNER 0440M 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Galesville 951 W. Benning Rd. If Under 1 Year | If Under 24 Hrs. Date of Birth (Month Day, Year) 11/24/1924 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Months 1 □ M 2 🗷 F MD 84 219-12-2866 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, tra Nacilcal Exa all set must be notified at 1 ∏Yes 2 Tx No Director Galesville MD Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20765 USA Funeral 951 Benning RD. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 ⊠ If Yes, Give Year or Dates: 2 🔀 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Black Specify: þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Brown William Weston ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Odenton, MD 21113 1338 Farrara DR. Clifton Weston Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or of once. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 7/17/2009 Glen Burnie, MD Atlantic Crematory 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☑No 9 ☐ Unknown this certificate has been signed by the al director, page 2 should be detached Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 24a. Was an autopsy perform 1 □Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 1 ☐ Yes 2 No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

DHMH 17 Rev 1/2001

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completed cause of death (Item 23a) (Type

29b. Signature and title of cartifier

Name and address of herson (w)

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Ex	amine

Funera

Directo permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Everning Trust be notified at

Baltimore, Maryland 21215-0036

Physicia /Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit

Division of Vital Records, P.O. Box 68760, JRW Regis

		For State Registrar	State of Maryla		•	t of Healtl e of Deat		-	giene Reg. No.	21111	9 24	899
		Decedent's Name (First, Middle, Last)						2. Date of De	ath			of Death
cia		David Alf	Carlson					July 2	20. 2	2009 Yea	8:0	$O A^M$
lica ine		4a. Facility Name (If not institution, give s	treet and number)		4b. City,	Town, or Location	on of Death			County of De		<u> </u>
		5410 Mallard Lan	ding Drive			Lothian			Ar	ne Arı	ındel ·	
ıl		5. Social Security Number 6. Sex		rs. last birtho	Months	1 Year   If Und Days   Hour	der 24 Hrs.	8. Date of Bir (Month, Da	th ay, Year)	(	irthplace (Stat Country)	e or Foreign
r		049-28-5557	W 20 F 7	1 Yrs	S.			Aug 1		37 C	onn.	
		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town o	r Location						10d. Inside	City Limits
	ρ	MD Anne Arun	del T	othiar	1						1 □ Y	es 2⊠No
	rec	10e. Street and Number	I I	Othica	10f. Zip	Code			10g. Citi	zen of What (	Country?	
	<u></u>	5410 Mallard Land	ing Drive			20711				USA		
	ner		2. Was Decedent Ever in	U.S.	13. Was Deced	ent of Hispanic	Origin? (Spe	cify Yes or No	)-	14. Race - Ar	nerican Indian	
	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:		1 □Yes	cify Cuban, Mexi 2⊠No <i>Spec</i>		Hican, etc.)		Black, Wh Specify:	White, etc. Whit	e
	etec	15. Decedent's Educi (Specify only highest grade	ation	16a. D	ecedent's Usua	al Occupation	nost of workin	ag.	16b. Ki	nd of Busines	s/industry	
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	ဒ္	12		IN &	ival Ar	chitect		/P**			partmen	. t
	Be	17. Father's Name (First, Middle, Last)  Alf Ragnar Carl	con			18. Mc		(First, Middle	, ivialden	Surname)	Tundom	
1	င္	Alf Ragnar Carl  19a. Informant's Name/Relationship (Typ		10h N	failine Address	(Street and Nu	Dagny	I Clauta Numb	or City o	r Town State	Lundgr	en
		Jean Carlson (wif	, and the second second		•	•						4
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olice		21. Signature of Enteral Service Licenser	Coff			nd Address of Fa Souther					alvert, gs, MD	PA 20736
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	Tica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - A building, etc. (Spe	t home, farm	, street, factory	, office	2	8f. Location (	Street an	d Number or	Rural Route N	umber,
	Certification: To	4 ☐ Homicide determined	building, etc. (Spe	эсту)				City or To	wn, State	)		
29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day)										as stated. lue to the caus	e(s)	
:	<u>¥</u>	29b. Signature and title of certifier	1/		290	. License numb	er		29d. Dat	te signed (Mo	nth, Day, Year	)
		•	ntl	/		03-	3173			7-20	-09	
		30. Name and address of person who con Jonathan D. Lower				Road P	rince	Freder	ick,	MD 2	0678	
tate		31. Date filed (Month, Day, Year)	32. Registrate Sig		1 hor	Kel						
		VV	- Leven	/6	- Jan							

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	aryland / Depa <i>Ce</i> :	artment of He rtificate of De			giene <sub>Reg. No.</sub> 2 () () ()	24900				
	Physici	an	1. Decedent's Name (First, Middl	e, Last)				2. Date of Dea Month	Day Year	3. Time of Death				
-	/Medic	al	A. E. 19. A		othy Diamond		di d D db	July	18 2009	11:15 pM				
	Examin	er	4a. Facility Name (If not institution	, ,		4b. City, Town, or Lo	ederick		4c. County of Dea	m ederick				
	Funeral		5. Social Security Number	Living Center  6. Sex 7. Age	e (In yrs. last birthday)	If Under 1 Year	f Under 24 Hrs.	8. Date of Birth (Month, Day	h 9 Bir	thplace (State or Foreign				
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	pu:		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ncation				10d. Inside City Limits				
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	the N	Director	Maryland Fr  10e. Street and Number	ederick		10f. Zip Code	ana		10g. Citizen of What Co	puntry?				
	h with		9406 Br	igadoon Way			21704		U.	.S.A.				
	ems :	Funeral	11. Marital Status	12. Was Decedent B Armed Forces?	Ever in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Spe Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit					
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			23a. Part 1. Enter the disease of shock, or heart failure.	complications that caused only one cause on each lir	the death. Do not en		/	A .	1	Approximate Interval Between Onset and Death				
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Vital	Physician; The rthis certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:		Othor	6. Place of Death							
of		5	1 ☐ Yes 2 ☐ No  27. Manner of Death	1 ☐ Inpatie	ent 2 ER/Outpatie	III 3 L DOA	4 the Nursing Ho		lence 6 □ Other (Spe	ecify)				
on	ding Phi th. : After thi e funeral	tion	1 Natural 5 Pendir 2 Accident investi	ig (Month, Day	y, Year) Injury	Work?	s 2 No	200. 2000.120 //	ion injury document					
Division	I or Attending after death. Director; Afte I in by the fune	tific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		ury - At home, farm, str	reet, factory, office		28f. Location (S City or Tow	Street and Number or R	ural Route Number,				
	ital or ins aft al Dir led in	Certification:												
	the Hospital hin 24 hours a the Funeral I	ical	(Check only 2 Medical	ng Physician: To the best of Examiner: On the basis of	f examination and/or ir	th occurred at the time ovestigation, in my opir	e, date and place, nion, death occurr	and due to the red at the time, or	cause(s) and manner a date and place, and du	is stated. e to the cause(s)				
	To the Hospital or At within 24 hours after of Yo the Funeral Direct completely filled in by	Medical	one) 29b. Signature and title of certifie	and manner sta	ited.	29c. License r	number		29d. Date signed (Mon	th, Day, Year)				
	۵ څوځ	_	•		MA	05	8 391		077	09				
	<u></u>		30. Name and address of person	who completed cause of d	eath (Item 23a) (Type,	Print)	0011	1	2 7-20	1				
_			SAJJAO	A212, M	0.801	TollHe	wx A	ne F	rederie	li MD				
	Sta Registr		31. Date filed (Month, Day, Year)	2000 32 Registra	ar's Signature	e Ked		- /		21701				

Stat Registra

		For State Registrar	ricase	State o		nd / Dep		of Healt	h and M	lental Hy		9		21.901	
sicia	ın	1. Decedent's Name (	(First, Middle, La		ley		Deali			2. Date of De Month July 8	ath Da	Ea V	Year	3. Time of Death 10:19 A M	
edic min		4a. Facility Name (If r						vn, or Location		July 0		. County	of Death		
ral tor		Frederick 5. Social Security Nur 220-09-673	mber 6. 8	Sex I D M 2 X F		s. last birthday, 8 Yrs.	If Under 1		der 24 Hrs.	8. Date of Bir (Month, Da July 2	th ay, Year,		9. Birth	place (State or Foreign ntry) ginia	
TO THE PERSON NAMED IN	tor	Usual Residence of D 10a. State 1 Maryland	Decedent 10b. County Frederi	ck		City, Town or Li							10d. Inside City Limi 1		
AN AN AN AN	al Director	10e. Street and Numb		:t				10f. Zip Code 1 21769					/hat Cou	ntry?	
Evenin in	by Funeral	11. Marital Status 1 ☐ Never Married 3 ☑ Widowed 4		12. Was Dece Armed Fo 1 X Yes If Yes, Giver or D	rces? 2 ∐ No ve	U.S. 13.	Was Deceden If Yes, specify 1 □ Yes 2X			ecify Yes or No Rican, etc.)	-		k, White,	can Indian, etc. White	
The statement	Completed	(Specify Elementary/Second	5. Decedent's E y only highest gradury (0-12)	ducation ade completed) College (1	-4or 5+)	(Give	ia. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Personnel Officer					Cind of Bu		·	
diceren	To Be C		M. Ashl	Ley				18. M	other's Name lazel	e (First, Middle) Castee	1				
		19a. Informant's Nam Virginia L  20a. Method of Dispo	ewis/Dau		20h	711	4 Emera	ld Cou	ırt, M	al Route Numb iddleto Date	wn,	MD 2	21769		
e injury cr		1 Burial 2 4 Donation 5	Cremation 3 ☐ ☐Other (Speci	fy)	State	eltenh	osition (Name matory or othe am Ceme 2. Name and A	tery	7/21	. 1	Che	ltenh	am,N	AD	
once		23a Part 1 Enter the	e diseas com failure. List only	inlications that o	Om aused the de	e	1621 op	ossumt	own P	ike, Fr	ede				
an cal	2 /	Immediate Cause (Fi disease or condition resulting in death)		a. COP		equence of):								Onset and Death	
	cal Examiner	Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or in that initiated events resulting in death) La	_	c		a consequence of): a consequence of):									
	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2 No   9   Unknown   1   Unknown   2   Unkn								23d. Date Mon				very Day Year	
	þ	Part II. Other signific	ant conditions	contributing to de	eath but not re	esulting in the t	underlying caus	se given in Pa	art I.					the cause of death?	
	Completed									24a. Was auto perfo 1 □Yes		p	rior to co leath?	opsy findings available ompletion of cause of 2 □No	
5	n: To Be	25. Was case referre examiner? 1 ☐ Yes 2 ☑ N 27. Manner of Death	0	28a. Date	of Injury	XER/Outpatie		0.11	Nursing Ho	h (Check only only only only only only only only	dence			ify)	
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	29a. Certifier (Check only one)  29b. Signature and tile of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)									stated. to the cause(s)					
.\	M	29b. Signature and ti	le of certifier			P		053986				ate signed		, Day, Year) <b>)9</b>	
71		30. Name and address Jill A. D	urfee (	610 Sola	rex Co	ourt, f		k,MD 2	21703						
Sta Jistra		31. Date filed (Month	JUL 20	2009	enstrar's Sign	A. A.	pare	,							

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Rebecca	Ly

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becca Lynne	_	nano State of Maryland / Department of He 1- For State Certificate of De		id ivientai Hy		pull 40°	09 2490
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)	auı		2. Date of Death	g. No. h	3. Time of Death
edical Exami		Rebecca Lynne Fagnano			Month July 20, 20	Day Year )09	1136 hrs
		4a. Facility Name (if not institution, give street and number)  4b. Cit	•	r Location of Death		4c. County of Dea	th
			gerstow			Washington	
Funeral		7, 22, 24, 27, 27, 27, 27, 27, 27, 27, 27, 27, 27	Inder 1 Year		-	` 1 c	irthplace (State or Foreign Country)
Director		1 2 <u>2 2 1 3 0 113 1 1 3 0 113 1 1 3 0 1 1 3 0 1 1 3 0 1 1 3 0 1 1 3 0 1 1 3 0 1 1 3 0 1 1 3 0 1 1 3 0 1 1 3 0 1 1 3 0 1 1 3 0 1 1 3 0 1 1 3 0 1 1 3 0 1 1 3 0 1 1 3 0 1 1 3 0 1 1 3 0 1 1 3 0 1 1 3 0 1 1 3 0 1 1 3 0 1 1 3 0 1 1 3 0 1 1 3 0 1 1 3 0 1 1 3 0 1 1 3 0 1 1 3 0 1 1 3 0 1 1 3 0 1 1 3 0 1 1 3 0 1 1 3 0 1 1 3 0 1 1 3 0 1 1 3 0 1 1 3 0 1 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3 0 1 3</u>			3/12	/1973	MD
ù	ŀ	Usual Residence of Decedent         10c. City, Town or Location           10a. State         10b. County		<u> </u>			10d. Inside City Limits
id how a	L	MD Washington Smith	sbur	g			1 Yes 2 XNo
Maryland 28a-f show any d at once.	Director	10e. Street and Number 10f.	Zip Code		10	og. Citizen of What Co	untry?
the M		115 Joel Circle	21	783		USA	·
h with ms 23 be no	Funeral		edent of H	ispanic Origin? ( Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame White, etc.	erican Indian, Black,
r deat	튑	Never Married 2 Married 1 Yes 2 X No			. ,	Specify: Wh	nite
rs afte ural",		3 Widowed 4 X Divorced If Yes, Give Year 1 Yes  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Us		o specify: ation (Give kind of v	vork done	16b. Kind of Busines	
2 hou "nat	ed			e. DO NOT use reti		Ì	
036 ithin 7 ne. r than	Completed by	12 homes	make	r		own hom	ne
5-0 led w Hygie I other		17. Father's Name (First, Middle, Last)		18.Mother's Name	•		
121 d be fi fental narked event,	Be	Richard Ernest Brightwell  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Addi	race (Ctro	Sue Bra		S nber, City or Town, Sta	ate Zin Code)
Baltimore, MD 21215-0036  Depenit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department and Mental Hygiene in Pattural", or items 23a or 28a-f shou Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f shou injury or other traumatic event, the Medical Examiner must be notified at once.	의	Sue Yeager (Mother) 2504 K	aetz	el Rd.,	Knoxv	ille, MD	21758
e, N l and 2 Health item 2		20a. Method of Disposition 20b. Place of Disposition	Name of c	emetery,	Date	20c. Location - City	or Town, State
nor ages at of a		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition (crematory or Gien)  1 Specify:  20b. Place of Disposition (prematory or Gien)	Meth	odis 7/3	24/200	<b>9</b> Jefferso	on, MD
altin mit. P partme portat		4 Donation 5 Other Specify: 27 Syn ture of Specify ensee 22 Name	and Addres	Bof Facility Omi	oson F	uneral Ho	ome
E P P D		west none pob	18,	Middle	town,	uneral Ho MD 21769	
Physician /Medical	X	23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mo- failure. List only one cause on each line.				est, shock, or heart	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death)  a Trazadone and fluoxent:  Due to (or as a consequence of):	ine i	ntoxicati	on		Death
		Sequentially list conditions,  b					
	ner	if any, leading to immediate Due to (or as a consequence of):					
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
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be exestician	Physician/Medical	X UNPENDED AMENDED 23a,27,28a-f,per	ıe, g	094 0/3/0	9 11		
lox 68760, leath certificate be a sattending physicis for use as the buria	√/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de	eath 3	Ectopic pregna	ancv	23d. Date of deliv Month	ery Day Year
x 68 h certi tendin use a	icia	past 12 months?  4 Pregnant at time of death 5 Other (					
<b>—</b> 5 5 5 1	hys	1 Yes 2 No 9 V Unknown 9 Unknown		of and a Boat I	22a Did to	abana una contributo	to the cause of death?
s, P.O. B ires that the d signed by the	by F	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause	e given in Part I.	1 Ye:		robably 4 V Unknown
duires quires en sig					[ 24a. Was	an   24b. Were	autopsy findings available
cords, shaw require that been side to should be	ompleted					rmed? death	
Re The icate	Co		26 Dia	es of Dooth (Chook	1 Yes	2 No 1 🗸	Yes 2 No
Vital   ysician: his certifi director,	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3	DOA	Other: Nursi		Residence 6 Ot	her:
of Vital Records ling Physician: The law requii After this certificate has been funeral director, page 2 should	: To	27. Manner of Death 28a. Date of Injury 28b. Time of Injury		jury at Work?		how injury occurred	
<b>-</b> ∃ . ^ ≥ l	atior	1 Natural 5 Pending (Morth, Day, Yeár) 2 Accident Investigation Fd 7/20/09 Fd 10:54	am 1	Yes 2X No	unk		
Division tal or Attendirs after death. al Director:	Certification:	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, fac		e building, etc.	28f. Location (	Street and Number or State) 115 .Toe	Rural Route Number, City  L Circle
Spital hours a neral filled	Сеп	4 Homicide determined (Specify) house			Smiths	burg, MD	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:		29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred a come)  Wedical Examiner: On the basis of examination and/or investigation, it	it the time, n my opini	date and place, and on, death occurred	d due to the caus at the time, date	se(s) and manner as s and place, and due to	tated. the cause(s)
To the within To the comple	Medical	and manner stated.  29b. Signature and title of certifier		nse number		29d. Date signed (	
		Projek & Without was	0.0	C.M.E.		July 21, 2009	
		30. Name and address of person who completed cause of death (Item 23a)				٠	
		Pamela E. Southall, MD Assistant Medical Examiner 111 Pe	enn Stre	et, Baltimore, l	MD 21201		
		Od Data Stant (4.4. (4. Day March ) 200 Degistraria Signatura					

DHMH 17 Rev 1/2001 OCME 2006

Registrar

State of Maryland / Department of Health and Mental Hygie

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No							

Dhuaisian	
Physician	
/Medical	
Examiner	

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lajury or other traumatic event, it a Madical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Stat

1 - State Registrar			Cer	rtificate of	Death		Reg	g. No. 🗀 🔾		-770
1. Decedent's Name (First, Middle	, Last)						te of Death	Day	Voor	3. Time of Death
J09	EPH JAME	S GROH					onth ULY	19	Year <b>2009</b>	8:08 P
4a. Facility Name (If not institution	, give street and nu	ımber)		4b. City, Town, o	Location of D	Death		4c. Count	y of Death	
HOSPICE OF QUEE	N ANNE'S	HOSPICE (	ENTER	CEN	revill	Æ		OHE	EN AN	NE S
* * * * * * * * * * * * * * * * * * * *	6. Sex	7. Age (In yrs. la		If Under 1 Year	If Under 24	Hrs. 8, Da	te of Birth		9. Birth	place (State or Foreig
100-24-2281	1 <b>X</b> M 2□ F	77	Yrs.	Months Days	Hours 1	Min. DEC	onth, Day, ` FMBFR	rear) <b>16, 193</b>	Coui	YORK
Usual Residence of Decedent										
10a. State 10b. County		10c. City,	Town or Lo	cation					1	10d. Inside City Limit
MARYLAND QUE	EN ANNE'S			CH	ESTER					1 □Yes 2 🕱 No
10e. Street and Number	EN ANNE D	<u> </u>		10f. Zip Code	ESTER		10	g. Citizen of	What Cour	ntry?
	CAROT THE	COTTO			(10			TIME	m am.	mra
51 D QUEEN		edent Ever in U.S.	10.1		619	2 (Chaoify V	as or No	UNITE	_	can Indian,
11. Marital Status	Armed F	orces?	. 13. 1	Was Decedent of H f Yes, specify Cuba	ın, Mexican, P	uerto Rican,	etc.)		ck, White,	
1 Never Married 2 Marri 3 Widowed 4 Divorced		2 □ No ive	•	1 □ Yes 2 📉 No	Specify:			Speci	fy: WHI	TE
		Dates:1949-19			- 11		14	Db 16116.5		
15. Decedent (Specify only highes	's Education <i>t gr</i> ade co <i>mpleted)</i>	)	(Give	dent's Usual Occup kind of work done	during most of	f working	"	6b. Kind of E	susiness/in	dustry
Elementary/Secondary (0-12)	College (	1-4or 5+)	iire. L	DO NOT use retired					CATE	20
12				SALE					SALE	25
17. Father's Name (First, Middle, L	.ast)				18. Mother's	Name (First,	, Middle, Ma	aiden Surnai	me)	
ALF	BERT GROH				MAI	RIE BR	UCHSEI	L		
19a. Informant's Name/Relationsh	ip (Type. Print)		19b. Mailin	ng Address (Street	and Number o	or Rural Rout	e Number,	City or Towr	, State, Zij	o Code)
DOLORES GRACE G	ROH/WIFE		51 D	OUEEN CA	ROLINE	COURT	. CHES	STER.	MARYI	AND 21619
20a, Method of Disposition	11011	20b. Pla	ce of Dispo	sition (Name of		Date	20	oc. Location		
1 Burial 2 Cremation		State		natory`or other plac		JULY 2				
4 □ Donation 5 □ Other (Sp		CHES		E CREMAT		2009_	5:	LEVENS	VILLE	E, MARYLAN
21. Signature of Funeral Service L	icensee		FE		ELFENBE					HOME, P.
( /agre		40,40	10	06 SHAMRO	CK ROAI	D, CHE	STER,	MARYL	AND 2	21619
23a. Pari : Enter the disease, or shock, or hear failure. List of	complications that	caused the death.	Do not ent	er the mode of dyir	ig, such as cai	ırdiac or resp	iratory arres	st,		Approximate Interval Between
Immediate Cause (Final disease or condition	T 17	NG CANCE	D							Onset and Death  MONTHS
resulting in death)		(or as a conseque								MONTES
Sequentially list conditions, if any, leading to immediate	b Due to	(or as a conseque	ence of):			_ <del></del>				
cause. Enter Underlying Cause (Disease or injury	•									
that initiated events resulting in death) Last	c	(or as a conseque	ence of):	·						
		(								
3	d									
IF FEMALE:										
23b. Was decedent pregnant in the past 12 months?		itcome of pregnan birth 2  Fetal o		Ectopic pregnanc	y				ate of deliv Ionth	ery Day Year
1 ☐ Yes 2 ☐ No	4 ☐ Prec	gnant at time of de	ath 5□	Other (specify) _				"	Onui	Day Teal
9 Unknown										
Part II. Other significant conditio	ns contributing to o	leath but not result	ting in the ur	nderlying cause giv	en in Part I.	2:	3e. Did toba	cco use cor	ntribute to t	the cause of death?
						_	1 ☐ Yes	2 □ No	3 ☐ Pro	babiy 4🗶 Unknow
							4a. Was an	24h	Were auto	opsy findings availab
						-   -	autopsy		prior to co	empletion of cause of
						1	perforḿı □Yes 2.	No No	1 ☐ Yes	2 □ No
25. Was case referred to medical examiner?						f Death <i>(Che</i>	ck only one,	)		HOSPICE
1 ∏ Yes 2 📉 No	Hospital: 1	Inpatient 2 ☐ E	R/Outpatier	nt 3□ DOA Oth	er: 4 🗆 Nursi	ing Home 5	Resider	nce 6 🕱 Ot	ther (Speci	(b) CENTER
27. Manner of Death	28a. Date	of Injury oth, Day, Year)	28b. Time of Injury	28c. Injur Wor	y at	28d. D	escribe how	injury occu	rred	
1 X Natural 5 ☐ Pending 2 ☐ Accident investig	, ,	,9,,	,,		Yes 2 □ No	,				
3 ☐ Suicide 6 ☐ Could n	ot be 28e. Place	e of Injury - At hom ling, etc. (Specify)	ne, farm, str	eet, factory, office					ber or Run	al Route Number,
4 ☐ Homicide determine	- build	iing, etc. (Specify)				Ci	ity or Town,	State)		
29a. Certifier 1 X Certifying	g Physician: To th	e best of my know	ledge deat	h occurred at the ti	me, date and	place, and di	le to the ca	use(s) and r	nanner as	stated.
1   Yes 2   No   Notice   1   Inpatient 2   ER/Outpatient 3   DOA   Orner: 4   Nursing Home 5   Resident   2   Accident   1   Natural 2   Accident   2   Accident   3   Suicide   4   Homicide   28e. Place of Injury - At home, farm, street, factory, office   28f. Location of City or To   29a. Certifier (Check only one)   Check only one)   Check only one)   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, and manner stated.   29b. Signature and title of certifier   29c. License number										
A 1	and mar		29c. Licens	e numbor		20	d. Date sign	od (Month	Day Yearl	
29b. Signature and title of certifie	1 1000						29			
Harm	rull	VW_	•	D0	57936			JULY	20, 2	2009
30. Name and address of person v	who completed cau	se of death (Item :	23a) (Type,	Print)						
HEATHER D. MAN	NUEL. M.	D. 22 S	. GREE	ENE STREE	T, BALT	TIMORE	, MAR	YLAND	21201	
31. Date filed (Month, Dan Year)		Redistrar's Signatu		1						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 7/15/2009 **Physician** 0020 м Lawrence J. Goodman /Medical 4a. Facility Name (If not Institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Anne Arundel Medical Center **Annapolis** 8. Date of Birth (Month, Day, Year, 6/8/1950 9. Birthplace (State or Foreign Country) DC 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7, Age (In vrs. last birthday) **Funeral** 1 XM 2 □ F Months Days Hours 218-54-7353 59 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If them 27 is marked other than "natural", or thems 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a lifedical Examinat must be notified at 1 ☐ Yes 2 ☐ No Director MD Anne Arundel Shady Side 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20764 USA \_1179 Bayview Ave. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Ammed Poles: 1 1 ⊟Yes 2 □ No Vietnam IfYes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes XXNo Š Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Food 12 Sales Representative 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James F. Goodman Nancy V. Squier 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1179 Bayview Ave. Shady Side, MD 20764 Wife Virginia B. Goodman 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of I
important: if ite
any injury or ot 1 Xxurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery: 7/18/2009 | Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHardesty Funeral Home, P.A. once. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** avcinoma 01 MANCVERS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) P.0. After this certificate has been signed by the a funeral director, page 2 should be detached f 1∐Yes 2∐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u></u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2KNo 1 ☐Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

and manner stated. To the within 2 29c. License number
D 46052 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier peuBah, Mo 7/15/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sirly Beck, Hb 2001 Medical Panhway amapolis, MO Sirend Beck, HUB

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Si

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear **Physician** GILLIAM JR. CLAYTON 2009 JULY 6. 3:15A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S FORT WASHINGTON REHAB CENTER FORT WASHINGTON 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Vear Hours Min. 1 X M 2 □ F Months 75 578-42-6139 Director SULFORK, VIRGINIA 1934 JULY 1 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h Count show r than "natural", or items 23a or 28a-f sho the Wedical Evarrieur πust be notified at 1 □XYes 2 □ No Director PRINCE GEORGE'S OXON HILL MD 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code USA 20745 7408 OXON HILL ROAD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Year or Dates: ARMY Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No Specify. Specify: BLACK ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) STAIN GLASS ARTIST ENTREPRENEUR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be file tment of Health and Mental H tant: If item 27 is marked oth jury or other traumatic even Be ပ CLAYTON C. GILLIAM SR. MILDRED SYKES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DONYELL MARSH/NEPHEW 7408 OXON HILL ROAD OXON HILL, MARYLAND 20745 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation permit. Page Department of Important: If any injury or 3 Removal from State VETERANS CEMETERY 7/28/2009 4 ☐ Donation 5 ☐ Other (Specify) CHELTENHAM, MARYLAND 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funer Service Licenses 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician METASTATIC COLON CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or neitying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ∃Yes 2 □ No the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼ No 24a Was an has autopsy certificate 27 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 🔁 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. 2 Accident filled in by the 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral I Medical 29a, Certifier To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Let Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the within. 29b. Signature and fitt of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6 2009 D49255 JULY 20 30. Name and address of person w no completed cause of death (Item 23a) (Type, Print) EDGER VERDAN POTTER JR. MD. 1328 SOUTHERN AVENUE SE # 210 WASHINGTON, DC 20032

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day,

Year)

32. Registrar's Signature

within 24 hours a

Medical Certification: To T Ructured Heart 29b. Signature and title of certifier 29c. License number 30. Name and address of person who come eted cause of death (Item 23a) (Type, Print) Ste 2001 31. Date filed (Month, Day, Year State Registrar **ORIGINAL** 

2009 24907 Myra Marisol Martinez Hernandez State of Maryland / Department of Health and Mental Hygiene

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Physicia	ın/	I. Decedent's Name (First, Middle, L			_		2. Date of De Month July 27, 2		3. Time of Death 0652 hrs
edical Examii		Myra Maris		Iernande	BZ 4b. City, Town, or Lo	ocation of De		4c. County	of Death
		4a. Facility Name (if not institution, 9 8857 Garland Avenue	give street and number)		Silver Spring			Montgo	
Funeral		5. Social Security Number 6.	. Sex 7. Age (In yrs.	ast birthday)	If Under 1 Year	If Under 24	AT .		9. Birthplace (State or Foreign
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,1		30. Name and address of person	who completed cause of death (	tem 23a)					
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State of Maryland / Department of Health and Mental Hygiene o o o o

Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ital Mudical Examines must be notified at agine.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Sta Registr

	1 - For State Registrar		iai yiaira i		ificate of L				J. No.	7 64	200
	1. Decedent's Name (First, Middle, L.	ast)						Date of Death Month	Day Year	3. Time of	Death
an al	Thomas Hubbard						J	uly 20		6:00	PΜ
er	4a. Facility Name (If not institution, gr	ive street and numbe	r)	4	4b. City, Town, or		Death		4c. County of Dea		
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	19a. Informant's Name/Relationship Julia C. Hubbard				Address (Street a				City or Town, State,	Zip Code)	
	20a. Method of Disposition 1 ☐ Burial 2 ▼Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec				ion (Name of tory or other place mey Cren		Date 7 07/22		oc. Location - City o		
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	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,										
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۷ Ph	Part II. Other significant conditions	contributing to death	but not resulting in	the und	erlying cause give	n in Part I.		23e. Did toba	cco use contribute	to the cause of c	leath?
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Medical Certification: To	2 Accident investigation 3 Suicide 6 Could not to 4 Homicide determined	be 28e. Place of Ir	njury - At home, far etc. <i>(Specify)</i>	rm, stree			28f. I	Location (Stre City or Town,	et and Number or F State)		aber,
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	BouTIKA	- Emila	-fort	Type, Rr	200 E	21-10	1 fto	1219	MD 2	1227	
te ar	31. Date filed (Month, Day, Year)	0000	trar's Signature	19	arker				7	1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. -2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 0-James Horner 2009 William /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Miconico peninsula Regional Medical alisbur (enter If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Yea 04-10-192] 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Mary Land Days Months Hours 88 201-09-5036 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examinar must be nutilised at 1 Yes 2 □ No Director Crisfield MD Somerset death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21817 USA 101 South Somerset Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? within 72 hours after 1 XYes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 XNo Specify. Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If Item 27 Is marked other than any injury or other traumatic event than the teams of the teams of the traumatic event than the teams of the teams of the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that the teams that College (1-4or 5+) Elementary/Secondary (0-12) TV/Radio Repairman none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ada Bozman Milton James Horner 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dora E. Horner/wife 101 South Somerset Ave., Crisfield, MD 21817 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State St. Peter's U,M. Cem. 07/17/2009 Oriole, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hinman Funeral Home Signature of Funer M00295 11673 Somerset Ave., Princess Anne, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usaasseri jury) that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and -trar Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as asn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy for in the past 12 months? Month Year 5 Other (specify) □Yes \$2 No signed by the a O. 9 Unknown 9. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 □Yes 1 ☐Yes 2 ☐No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1XNatural 5 Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident 6 □Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Division

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, State Registrar

(Check only

Jogesh

29b. Signature and title of



and manner stated.

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

VOHRA

29c. License number

29d. Date signed (Month, Day, Year)

		•	State State Registrer	of Maryland		rtment of He tificate of D			giene leg. No.	09	24910
	· 25		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physicia /Medic	_	SYLVIA	KA	PLAN			JULY		00'9"	6:20 P M
	Examin		4a. Facility Name (If not institution, give street and	number)		4b. City, Town, or I			4c. Count	y of Death	
			Spring House Manor			Bethe				gomer	-
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las.	Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day June 5,	, Year)	Coun	lace (State or Foreign try) York
	Director	<i>1</i> 2	057-07-0433	93				June 3,	1910	New	IOLK
	yland Iow		10a. State 10b. County	10c. City, 1	Town or Loc	ation				11	0d. Inside City Limits
:	Mar.	ţ	MD Montgomery	Bet	hesda						1 ☐ Yes 2 🔼 No
-	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	try?
	23a c	ai	5603 Ridgefield Road			20816	5		United	State	es
-	ema Fr	Funeral	11. Marital Status 12. Was D Armed	ecedent Ever in U.S. Forces? s 2 \( \overline{N} \) No	13. W	as Decedent of His Yes, specify Cuban	panic Origin? (Sp , Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra Bia	ce - Americ ack, White,	
9 :	or le	by Fu	If Yes.	Give	1	☐ Yes 2X No	Specify:		Speci	fy:	<b>h</b> 4 4 a
5.	tural'		15. Decedent's Education	r Dates:	16a Deced	ent's Usual Occupa	tion		16b. Kind of E		hite
2	"na" r	ojet	(Specify only highest grade complete	ed)	(Give F	kind of work done du O NOT use retired)	aring most of work	ing	TOO. TRITING OF E		
7	the in	Completed	Elementary/Secondary (0-12) Colleg	e (1-4or 5+)	Secr	etary			NY City	y Welf	are Dept.
2	Hyg other	a l	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Suma	me)	
2	should be filed within 72 hours after death with frie maryland ind Mental Hygiene. Ind Mental Hygiene. In marked other then "natural", or itema 23s or 28s-f show umatic event, if a Mouldal Exercitar must be notified.	ToB	Elias Siegel				Ida		"Unkno	own''	
<u>a</u>	permit. Pages 1 and 2 should be tiled within 72 hours after dearn with the marylan permit. Pages 1 and Solution by the marken of Health and Mental Hygiene. Important: If tiem 27 is marked other then "natural", or Itema 23a or 28a-f show eny Injury or other traumatic event, the Modical Exeminar must be notified at once.		19a. Informant's Name/Relationship (Type, Print)	1		g Address (Street a		al Route Numbe	r, City or Towr		
¥ .	and salth n 27		Richard Kaplan, son			idgefield		Bethesd		20816	
5	rages 1 in the nent of He ant: If item arry or oth		20a. Method of Disposition 1   ☐ Burial	20b. Plac cerr	e of Dispos netery, crem	sition (Name of atory or other place	)	Date	20c. Location	- City or To	wn, State
,	ment ment: I ant: I		4 Donation 5 Other (Specify)	New 1		fiore Cem	-	/2009			
מַ	Depart Depart Import eny Inj once.		21. Signature of Funeral Service Licentae								Home, Inc.
_	70 E 9 9		Jary / h/ or	Lui						Spring	, MD 20904
			23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of	at caused the death. In each line.	Do not ente	ir the mode of dying	, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
F	hysician			EUMONIA							
١,	/Medical Examiner			to (or as a conseque							
÷.	- Adminion	ų.	Sequentially list conditions, b. CH	RONIC LYMI		IC LEUKEN	MIA				
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	to (or as a consequen	nce or,						
	xecul and al-trar	хап	that initiated events c	to (or as a conseque	nce of):						
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0	mcare g phy	Physician/Medical									
<b>S</b>	instine death certification by the attending place detached for use as t	/W		outcome of pregnanc		F-1			23d. D	ate of delive	ery
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ב =	ate h	Completed							rmed? 2∑ No	death? 1 ☐ Yes	2 🗆 No
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<u> </u>	after c Direct I in by	Certification:	4 Homicide determined	uilding, etc. (Specify)	0, 10,111, 0110	ot, lactory, cinoc		City or Tov			
	spira cours heral filled		29a. Certifier 1X Certifying Physician: To	the best of my knowle	edge, death	occurred at the tim	e, date and place,	and due to the	cause(s) and n	nanner as s	lated.
:	To the Hospital or Attenwithin 24 hours after deall To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Examiner: On th								
	vithir To th comp	Me	29b. Signature and title of certifier			29c. License	number		29d. Date sign	ed (Month,	Day, Year)
			) / mx		)	D3557	'9		July 20	, 200	9
1	_		30. Name and address of person who completed of			Print)					
				218 Wiscon			305 Bet1	nesda, N	D 208	14	
	Sta		31. Date filed Menth, Day, Year)	2. Bagistrar's Signatur	lan.	10					
	Registi	ar	JUL 21 2009 A	com p.	xquare	1					

ulia A. Litz	State of Maryland 1- For State Registrar	Department of / Certificate of	Health and Mental H Death	ygiene <sub>Reg.</sub>	No. 20	09 249
Physician/ Medical Examine	Decedent's Name (First, Middle,Last)			Date of Death     Month     Death	Day Year	3. Time of Death 0040 hrs
medicai Examine	Julia Ann Litz  4a. Facility Name (if not institution, give street and number)	14	b. City, Town, or Location of Death	July 27, 200	4c. County of Deat	
	3932 7th Street		North Beach		Calvert	
Funeral Director		e (In yrs. last birthday)	If Under 1 Year If Under 24Hrs  Months Days Hours Min	. 8. Date of Birth	Forei	rthplace (State or gn
Director	544-94-4898 1 M 2XF	46 Yrs.		09-14-	1962	ountry) Missouri
any	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Locati	on			10d. Inside City Limits
and show	MD Calvert	Nort	ch Beach			1 X Yes 2 No
the Maryland a or 28a-f show any tified at once. Director	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Cou	untry?
auth with the Maryland items 23a or 28a-f she set be notified at once in the maral Director			20714		USA	
ar death with or items 23 must be no	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2	Ever in U.S. 13. Was	s Decedent of Hispanic Origin? ( Spes, specify Cuban, Mexican, Puerto		14. Race - Ame White, etc.	rican Indian, Black,
A PELL		No 1	Yes 2 X No specify:		Specify: W	hite
hours aft natural' Examing		during me	t's Usual Occupation (Give kind of ost of working life, DO NOT use ret		6b. Kind of Business	
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	Charles Ev	ans	Patrici		Giese	
			Address (Street and Number or I		•	
e, MD and 2 sho lealth and item 27 is traumati	Patricia A. Herendeen, mot 20a. Method of Disposition	20b. Place of Dispos	Briargrove Lane		20c. Location - City o	
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Baltimore, permit. Pages I at Department of Hee Important: If ite njury or other tr	21. Signature of Funeral Service Licensee		ame and Address of Facility Ra			
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Physician /Medical	23a. Part I. Enter the disease, or compilations that caused failure. List only one cause on each line.				t, shock, or heart	Approximate Interval Between Onset and Death
xaminer	Immediate Cause (Final disease or condition resulting in death)  a. Morphine  Due to (or as a const		tal intoxication	n		Death
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). Box the death the death by the atternate for a Physics	1 Yes 2 No 9 V Unknown g Unknown	3 00	ner (Specify)			
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ords, P.C. w requires that s been signed should be deter				24a. Was ar		autopsy findings available
of Vital Records, ge Physician: The law requires the this certificate has been signeral director, page 2 should be not to Be Completed	<u> </u>			autopsy	prior to	completion of cause of
Vital Recysician: The Inscertificate Indirector, page	25. Was case referred to medical		26.Place of Death (Check	1 Yes 2	No 1 🗸	Yes 2 No
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Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral ledical Certification:	3 Suicide 6 X Could not be determined Specify f	ound at home form, street ound at home	et, factory, office building, etc.			Rural Route Number, City
Hospit 24 hour Funers rely fill	29a. Certifier Check only 1 Certifying Physician: To the best of m	y knowledge, death occur	red at the time, date and place, and	North Be		ated.
To the Hos within 24 h To the Fur completely	one) 2 Medical Examiner: On the basis of exa					
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	D_M _ IM		O.C.M.E.		July 27, 2009	
	30. Name and address of person who completed cause of components. Wincenti, MD Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assistant Medical Assis	al Evaminas 444	Penn Street, Baltimore, M	1D 21201		
State	31. Date filed (Month, Day, Year) 2009 32. Registra	r's Signature				
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DHMH 17 Rev 1/2001

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			For State	State of Ma	aryland /		rtment of F tificate of		ind Mental H	0	000	21.012
			Registrar  1. Decedent's Name (First, Middle, La	ast)	-	Cei	incate of	Dealli	2. Date of E	Reg. No.	UUJ	3. Time of Death
	Physici			Millian					Month 7–28	-2009	Year	1:45 P M
A	/Medic Examir		4a. Facility Name (If not institution, gi				4b. City, Town, o	r Location of			unty of Deat	
,			Golden Living				Freder				ederi	
	Funeral Director			Sex 7. Ag 1 □ M 2 🔀 F	e (In yrs. last b	virthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Date of E (Month, 6–15–	Day, Year)	9. Birt	thplace (State or Foreign ountry)
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	wn or Lor	eation					10d. Inside City Limits
	f sho	ō		ad als		rmon						1 □Yes 2 XNo
	r 28a	irec	MD Freder	LICK	IIIU	LIIOH	10f. Zip Code			10g. Citizen	of What Co	ountry?
	h with	Funeral Director	11208 Putman Road	d			2178	8		J	JSA	
	ems	ıner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. V	Vas Decedent of F	lispanic Orig	in? (Specify Yes or N Puerto Rican, etc.)	No- 14.	Race - Ame Black, White	erican Indian,
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ryla	should be fand Mental series marked or umatic eve	٩	James Joy	(Torre Deine)	46	No. B. 8 - 111 -	- A -l-l (Ot		en Trundle		04-4-	7:- 0-4-)
Mai	d 2 sh Ith an IT is r traur		19a. Informant's Name/Relationship  Kim : McMillian	(Type. Print) Daugh			•		r or Rural Route Nun [hurmont ,	-		zip Code)
	t and f Health liem 27		20a. Method of Disposition				sition (Name of natory or other pla		Date			Town, State
E O	Pages nent of int: If its iry or o		1 Burial 2 ☐ Cremation 3 E 4 ☐ Donation 5 ☐ Other (Spec				natory or otner pia n Mem Grd	i -	3-1-2009	Freder	ick.	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Macinal Eventinal Perrollified at once.		21. Signature of Funeral Service Lice		01176	22	. Name and Addre	ss of Facility	Keeney & Street Fr	Basford	d P.A.	F.H.
			23 Part Inter the disease, or cor	nplications that caused	the death. Do						c, MD	Approximate Interval Between
100	Physician	Н	ck, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each li	Schn	2170	Coruma	ny A	ntery D	Kenes	-	Onset and Death
	/Medical	П	resulting in death)	a	a consequence						•	
	Examiner	ايرا	Sequentially list conditions,	b. Colon	CA	5						
	nsit	Examiner	Gacumile y list candilens if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence	e ory:						
Ć,	cate be executed physician and the burial-transit	Еха	that initiated events resulting in death) Last	c Due to (or as	a consequence	e of):						
68760,	ate be nysicia he bur	edical		d								
39 >	ertifica ling ph e as th	Med	IF FEMALE:							1		
Вох	eath certifi attending for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome  1 Live birth	2 Fetal dea		Ectopic pregnand	у		23d.	Date of del Month	livery Day Year
0	res that the de signed by the a be detached t	ıysic	1 ☐ Yes 2 DNo 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	it time of death	5 L	Other (specify) _					
о. С	s that ned b	by Ph	Part II. Other significant conditions	contributing to death b	ut not resulting	in the ur	iderlying cause giv	en in Part I.	23e. Die	d tobacco use o	contribute to	the cause of death?
Vital Records,	w requires been sig should be								1	]Yes 2□N	o 3□ P	robably 4 Unknown
ecc	e law re has be je 2 sho	Completed							24a. Wa	as an 2	4b. Were at	utopsy findings available completion of cause of
<u>=</u>	The cate h	8							pe 1 □ Yes	rformed?	death?	s 2 No
/ita	sician: The certificate rector, pag	Be (	25. Was case referred to medical examiner?					. ,	of Death (Check only			
of	Physi this o	ဍ	1 Yes 2 No		ent 2 ER/C	Outpatien . Time of	t 3 🗆 DOA		rsing Home 5 Re			ecify)
on	ding Ph h. After th funeral	tion	27. Manner of D th  Natural 5 ☐ Pending  Investigation	28a. Date of Inju (Month, Da	y, Year)	Injury	28c. Inju Wor M 1 [	ryat * k?  Yes 2		e how injury oc	curred	
Division	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification:	2 Accident investigation 3 Suicide 6 Could not I 4 Homicide determined	28e. Place of Ini	ury - At home, c. (Specify)	farm, stre	eet, factory, office		28f. Location	(Street and No	umber or R	ural Route Number,
	pital o		29a, Certifier 1 Certifying P			an doath	a conversed at the t	me dete en	d place, and due to t	ho aquas(a) an	d manner a	a atata d
	he Hos in 24 ho he Fun pletely	Medical		hysician: To the best miner: On the basis of and manner st	of examination a							
	Vithi Con	Ž	29b. Signature and title of certifier				29c. Licens		-1		-	th, Day, Year)
								1795	)	01-		-2009
			30. Name and address of person who	completed cause of d	8 14	(Type, I	oll Hous	E AU	E. FREDE	PRICK,	My	21701
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registr	r's Signature	A.	park	,				

DHMH 17 Rev 1/2001

**Physician** /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

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Department of Health and Mental Hygiene. Important: If Item 27 is marked other that any Injury or other traumatic event, the Nonce.

Director

Funeral

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Completed

Be

2

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

within 24 hours af er death.

To the Funeral Director: A completely filled in by the fu

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

	4 □ Donation 5 □ Other (Specify)	Ve	are cremat.	LOIT	0/3/0	9	SillyLI	ia, Di.		
	21. Signifure une 15 asset	M00!	Gale	e and Address of Fa ena Funera West Cros	l Home	of Ste Salena	ephen	L Sc 21635	haech	J
	23a. Part. Enter the disease, or complic shock, or heary failure. List only one	ations that caused the dea e cause on each line.							Approximate Interval Betweer Onset and Deat	
	Immediate Cause final disease or condition resulting in deaty	ALZHE Due to (or as a consec	uence of):	DISE	EASE	•			>5yea	us
niner	Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consec	quence of):							
ical Exar	that initiated events resulting in death) Last	Due to (or as a consec	quence of):							
Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ac. If yes, outcome pf pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 □Ectop	ic pregnancy r (specify)			23	d. Date of del Month	ivery Day Year	
	Part II. Other significant conditions conf	tributing to death but not re	sulting in the underlyi	ng cause given in Pa	art I.	23e. Did to			the cause of death	
Completed by						24a. Was autor perfo 1∐ Yes		prior to death?	utopsy findings avail completion of cause 2 No	lable of
Be (	25. Was case referred to medical examiner?									
10	1 Yes 25 No	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 47	Nursing Home	5 ☐ Resid	dence 6	□Other (Spe	cify)	
	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2	280	d. Describe I				
Medical Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Spec	nome, farm, street, fa	ctory, office	28f	f. Location ( City or To	Street and wn, State)	Number or R	ural Route Number,	
dical (	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my kneer: On the basis of examinand manner stated.	owledge, death occu ation and/or investig	rred at the time, date ation, in my opinion,	e and place, and death occurred	d due to the at the time,	cause(s) a date and	and manner as place, and due	s stated. e to the cause(s)	
Me	29b. Signature and title of certifier	le mo		29c. License numb	41587	7	29d. Date	signed (Mont	2009	

State Registrar

DHMH 17 Rev 1/2001

14,

DIL

122 Speer Rd. Chestertown, MD. 21620

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Helen A. Noble, M.D.

31. Date filed (Month, Day, Year)

7/30/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗸 U U S State
Registrar AMEND#9perINF, 7-27-09, BMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 2:57M **Physician** July 17, Murphy Everett Duane /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Montgomery General Hospital Olney If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day You 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 1919 Min. Hours 1**⊠**M 2□F Months Days 189-24-8299 89 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than المعلنية -- ". 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County iral", or items 23a or 28a-f shore 1 Tyes 2 XNo Director Rockville Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20853 14635 Bauer Drive Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married White If Yes, Give Year or Dates: 1937-47 1 ☐ Yes 2 😿 No Specify \$ Specify: ₩ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Computer Technician Federal Government 2 18. Mother's Name (First, Middle, Maiden Surname)
Minnie Chapman 17. Father's Name (First, Middle, Last) Be Everett Murphy ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4856 Sweetbirch Drive, Rockville, MD 20853 f Health tem 27 i Gail H. Bigio/Daughter 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Inportant: If ite any injury or of 1 € Burial 2 Cremation 3 Removal from State Quantico National Triangle, Virginia 4 Donation 5 ☐ Other (Specify) Cemetery 22 Name and Address of Eachth Francis J. Collins Funeral Home 500 University Blvd. W., Silver 21. Signature of Funeral Service Licensee Inc. Spring, MD 20901 Part1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part 1, Enter the disease. Immediate Cause (Final DULMONARY FIBROSIS 2 46 ARS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical the 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) □Yes 2 □No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 🗍 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 **2** No 2 🗷 No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 1 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To

Physician: The law requires that the death certificate be executed Box 68760. P.O. of Vital Records. Division or Attending

21215-0036

Baltimore. Maryland

Pages 1

after death. filled in by 24 hours a Funeral I

To the l within 2.

Hospital

Medical

ou Later

5 Pending

investigation

6 Could not be determined

29c. License number 023630

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) JULY 17, 2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009

Date of Injury (Month, Day, Year)

16226 FREDERZCK BD AZIZ GAZTHERIBURG, MARYLA-8 26877 FRANK J. MAYO

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

31. Date filed (Month, Day, Year) State Registrar

27. Manner of Death

1 X Natural

2 Accident

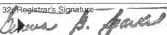
3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier



State of Maryland / Department of Health and Mental Hygiene 2 0 0 Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Miller **Physician** Allen Leslie 2009 10:55 July 18, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth (Month, Day, Year) Nov. 2, 1 9. Birthplace (State or Foreign Country)
D • C • If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 1946 578-58-5900 62 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Engine, must be matified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director Maryland Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20852 USA 257 Congressional Lane, Apt. 211 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Marketing Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)
Daniel Miller Be Ruth Grossman ပ္ 20852 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 257 Congresssional Ln., #211, Rockville, MD Cindy R. Miller/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State July<sub>9</sub>22 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Norbeck Memorial Park 22. Name and Address of Facility 21. Signature of Funeral Service Lice Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring,MD 20901 Approximate Interval Between Onset and Death lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. 23a. Part 1. Enter the disease, or d shock, or heart failure. List o Immediate Cause (Final DLS 6 AJE **Physician** CORONARY /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be ver hours after death.

Funeral Director: After this certificate has been signed by the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached for ☐Yes 2☐No 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 💹 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ∐Yes 2 🐪 Ño 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 20057124 uns 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Truong Bao, MD 10110 Molecular Drive, Rockville, MD 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature State parket 21 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Peath 1. Decedent's Name (First, Middle, Last) Day Year Month Physician 9:00 p July 14, 2009 James M. Martin /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Laurel Regional Hospital Laurel Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1**X** M 2 □ F 462-09-3131 95 May 15, 1914 Texas Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 TNo Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number "natural", or items 23a or 20904 USA 3128 Gracefield Road, Apt. 124 Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1XYes 2 No If Yes, Give WWII Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry ed other than "natu 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Physicist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)
Jesse C. Martin Be Anna P. Brooks 2 traumatic 20904 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3128 Gracefield Rd., Apt. 124, Silver Spring, MD Margaret M. Martin/Wife Item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or ot Metropolitan Crematory July 17 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Francis Address of Tilins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Dementia burial-trar Due to (or as a consequence of) Physician/Medical the g IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🚰 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed 2 No 1 ☐ Yes 2 ☐ No 1∐ Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2KKNo 1 Inpatient 2 KER/Outpatient 3 DOA funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1X Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

be executed Box 68760 P.O. or Vital Records, Division

Baltimore, Maryland 21215-0036

Pages 1

nding physician signed by the a certificate spital or Attendlours after death.

neral Director: A death. Hospital of 24 hours at To the Hospital within 24 hours a To the Funeral I completely filled

4 Homicide

(Check only one)

29a, Certifier

determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

umang MI over

D59524

July 16, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loveen Puthumana, MD

3110 Gracefield Road, Silver Spring, MD 20904

State Registrar 31. Date filed (Month, Day, Year) 21 2009



DTI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 16, July 2009 12:50 p.M Joanne Meyers /Medical 4c. County of Death Frederick 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Sommerford Assisted Living Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖫 F 74 340-26-3641 Director Illinois Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Modical Examinat must be positived at Yes 2 No Director Woodstock Illinois McHenry 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Hygiene. USA 60098 513 Springcreek Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white ไ∐Yes 2XINo If Yes. Give Specify ģ 3 X Widowed 4 ☐ Divorced Year or Dates Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygier. I I frem 27 is marked other the any Injury or other traumatic avent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Frame Ann Larsen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14009 Harrisville Road, Mt. Airy, Maryland 21771 Pamela Gallo - daughter Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Stauffer Crematory 7-17-2009 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service; Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final andro myopa Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760. the attending physician Physician/Medical the as nse 23c. if yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2√No P.0. 9 Unknown 9 Unknown ģ signed by be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown page 2 should Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 □ Yes 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6X Other (Specify) Assisted 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) Living To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 27. Mann of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1. D latural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registra DHMH 17 Rev 1/2001

State

(Check only one)

29b. Signature and title of certifier

Hemen Shah, M. D.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Cleneura

29c. License number

126041

65 C Thomas Johnson Drive, Frederick, Maryland

29d. Date signed (Month, Day, Year)

21701

			For State Registrar	State	of Marylan	•	rtment of <i>tificate o</i> i		d Mental Hy	giene Reg. No. 2 ()	09	24918	
ı	Physicia	an	1. Decedent's Name (First, Middle		0				2. Date of De	eath Day	Year	3. Time of Death	
	/Medic	al	Charles Calv  4a. Facility Name (If not institution				4b. City, Town,	or Location of De	July	16 4c. County	2009 of Death	9:10 A M	
	LAAIIIII	CI	1986 Valley Ro					nnapolis		Anne Arundel			
	Funeral Director		5. Social Security Number 215–16–7269	6. Sex <b>1</b> √2√M 2 ☐ F	7. Age (In yrs. 87	last birthday) Yrs.	If Under 1 Yea Months Day			10, 1922	9. Birthpl Coun Pen	lace (State or Foreign try) nsylvania	
	and w		Usual Residence of Decedent  10a, State 10b, County		10c. Cit	v. Town or Loc	cation				10	0d. Inside City Limits	
	Maryla	ctor		Arundel				Annapoli	.S			1 ☑ Yes 2 ☐ No	
	h with the	Funeral Director	10e. Street and Number 1986 Valley Ro	ad			10f. Zip Code	21401		10g. Citizen of What Country? U.S.A.			
0000	filed within 72 hours after death with the Maryland Hygiene. vither than "natural", or items 23a or 28a-f show ant, the Medical Examinar must be notified at	To a. State   10b. County   10c. Ci				Vas Decedent of Yes, specify Cu □Yes 240XN	Hispanic Origin? ban, Mexican, Pu o Specify:	5 14. Rad Bla Specif	ce - Americ ck, White, e y: Whi	etc.			
0-01	in 72 ho	Completed	15. Deceden (Specify only highes	st grade completed,			lent's Usual Occ kind of work don OO NOT use reti	upation e d <i>uring most</i> of v ed)	vorking	16b. Kind of B	usiness/Ind	dustry	
7	ygiene ygiene ner thau		Elementary/Secondary (0-12)		(1-4or 5+)	Pr	roduce M				ery S	Store	
/land	uld be filk Mental H Irked oth	To Be	17. Father's Name (First, Middle, Fred Milburn	Last)					lame (First, Middle la Ruth T		ne)		
Mar	nd 2 sho alth and 2 27 is me		19a. Informant's Name/Relations Estelle O. Mi		ē		g Address <i>(Stre</i> <b>Valley</b>		Rural Route Numb Annapoli:			<sup>Code)</sup> 21401	
ore,	ges 1 a t of Hea If item or othe		20a. Method of Disposition <b>XX</b> Burial 2 ☐ Cremation	3 ☐ Removal from	State	cemetery, cren	sition (Name of natory or other p		Date	20c. Location	•		
ранытог	nit. Pagartmen ortant; Injury	1	4 □ Donation 5 □ Other (S	pecify)	Lake		Iem. Gar Name and Add	I .	18/2009 ohn M. Ta			e, Maryland Home	
ם ם	Depar Impor any Ir once.	j. j.	) Todd	E &	elle							MD 21401	
			23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	only one cause on	each line.							Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a	(or as a conseq				-ung	DISET	><	20900	
	Examiner	-i-	Sequentially list conditions,	b. Due to	chem o (or as a conseq	uence of):	Laro	diom	yopat 1	4		1 year	
	ocuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	С									
0/00,	ficate be executed physician and s the burial-transit	al Ex	resulting in death) Last	Due to	o (or as a conseq	uence of);							
	rtificate ng phys as the	<b>ledical</b>	IE EEMALE.	d									
O. DOX	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	utcome of pregna e birth 2 ☐ Feta gnant at time of o nown	al death 3	Ectopic pregna Other (specify)				ate of delive onth	ery Day Year	
ν, Γ	gned by	by Ph	Part II. Other significant condition	ons contributing to	death but not res	ulting in the ur	iderlying cause (	given in Part I.				ne cause of death?	
cords,	requir been s									Yes 2 No	3 Prob		
al nec	n; The law ficate has r, page 2 s	Completed							1 □ Yes	opsy ormed? 2 No		psy findings available mpletion of cause of	
A   [2]	ysicial is certi directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	Inpatient 2	ER/Outpatien	t 3□ DOA C	thar:	g Home Res		her (Specif	iy)	
Sion of	nding Physician: th. : After this certifica ? funeral director, p	tion:	27. Manner of Ceath  1 Natural 5 Pendin 2 Accident investig	g (Mo	e of Injury onth, Day, Year)	28b. Time of Injury	W	ury at ork? □Yes 2 □ No	28d. Describe	how injury occur	red		
	tal or Atter	Certification:	3 Suicide 6 Could determ	ingd   286, Plac	e of Injury - At he ding, etc. (Specil	i ome, farm, stre fy)	eet, factory, office	e	28f. Location City or To	(Street and Num wn, State)	ber or Rura	al Route Number,	
	Hospi 24 hou Funer etely fill	2 Accident 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 20055542								stated. the cause(s)			
•	To the vithin To the Comple												
	12/0		30. Name and address of person Ruth Robinson		use of death (Iter			anoli-	Maryland	24.404			
				COO DES	regare M	July 17 1	Ariri	actives.	rat Viand	21401			
	Sta		31. Date filed (Manth, Day, Year)	2009	Registrar's Sign			aports,		21401			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** a M 2:30 July 19, 2009 Gertrude J. Monaco /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges 8438 Ravenswood Road New Carrollton If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Dec. 16,1915 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2X F 93 Massachusetts Director 212-09-6992 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2X No Directo Maryland Prince Georges New Carrollton 10g. Citizen of What Country? 10e. Street and Number 20784 U.S.A. 8438 Ravenswood Road Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
Int; If item 27 Is marked other than "natural", or items 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: White 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dennis O'Leary Ellen Fawley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Paul Robb 1795 Cameron Ct. Crofton, MD 21114 (Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cemetery July 23,2009 Washington, DC 4 ☐ Donation ☐ Other (Specify) 22. Name and Address of Facility Rendon/Hale Funeral Home 21. Signature of Funeral Service Licensee 9013 Annapolis Rd. Lanham, MD 20706 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SCHEMIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit DIABETES MELLITUS that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Month Dav Year 5 Other (specify) ed by the a detached for 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by PAINAND SWETUNG OF LEG 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown peen : 24b. Were autopsy findings available prior to completion of cause of death? HYPOTHYROI DISM 24a. Was an has autopsy performed 1 ☐Yes 2 ☐No CAROTID certificate STENDIIS 1 ☐ Yes 2 ☑ No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To ours after death.

neral Director: After this filled in by the funeral d 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

24 hours a To the within 2

State Registrar

29a. Certifier

Chrencyno 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carol Pressey

29d. Date signed (Month, Day, Year) 29c. License number

and manner stated.

3169 Braverton St #108 Edgewater, MD 21037

[ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

31. Date filed (Month, Day, Year)

29b. Signature and title of cortifier

32. Registrar's Signature

#### 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month, **Physician** Harry Mc Fadden JOLO 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CIVISTA MEDICAI ENTER 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F 577-66-8065 61 Director S -11-1948 Usual Residence of Decedent 10c. City, Town or Location 10a. State 28a-f shov injury or other traumatic event, the Medical Examinar must be notified at MD Charles Waldorf Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or 6727 Dolphin Ct. 20603 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No ģ HARRY 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filled within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Manager 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charlie Mc Fadden Henrietta Gallishaw ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6727 Dolphin Ct. Waldorf MD. 20603 19a. Informant's Name/Relationship (Type. Print) Casandra Mc Fadden (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7-25-2009 Ft. Lincoln Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hunt Funeral Home 908 Kennedy St. N.W. Wash, D.C. Mund praces 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** clem disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-tran certificate be exect Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.0. the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ Completed page 2 s has certificate Division of Vital 1 □ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
>
> 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2:20 No 2 □No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

23d Date of delivery

Day

Year

Month

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

20011

Approximate Interval Between Onset and Death

1 ☐ Yes 2 No

Wash.

14. Race - American Indian,

Black White etc.

Specify: Black

Washington Post

Day

2009

4c. Gounty of Death

U.S.A.

16b. Kind of Business/Industry

Brentwood MD.

3

2

After t

n 24 hours after the Funeral Director: Af inletely filled in by the funeral Director.

**Hospital or Attending** 

and manner stated. 29b. Signature and title of certifier 1 aguer

5 Pending

investigation 6 Could not be determined

> 29c. License number -00550863

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

31. Date filed State Registrar

မှ

Certification:

Medical

1€ Yes 2 No

27. Manner of Death

14 Natural

2 Accident

4 ☐ Homicide

(Check only one)

3 ☐ Suicide

29a. Certifier

Mes. PL 65 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28a. Date of Injury (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Mitchell Allen D. 12:37 2009 July 16, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico Salisbury 7485 Titleist Drive Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, **Funeral** Min. Months Days Hours 1 X M 2 □ F 217-54-7404 Maryland 02/21/1951 58 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ▼ No Director Salisbury Wicomico Maryland 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 21801 USA 7485 Titleist Drive 23a Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 5 If Yes, Give Year or Dates: 1 ☐ Yes 2 👿 No Specify Marine Specify: white 2 3 X Widowed 4 ☐ Divorced "natural", Corp Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 th and Mental Hygiene. 7 Is marked other than "n: Elementary/Secondary (0-12) College (1-4or 5+) gas company truck driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Geraldine Wright Alan Mitchell ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7550 Titleist Dr., Salisbury, MD 21801 19a. Informant's Name/Relationship (Type. Print)
Geraldine Mithcell/mother permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is in any injury or other traum once. 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/20/09 Salisbury, MD Parsons Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Holloway Funeral Home Professional Association 21. Signature of Funeral Service Lices 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** avdion disease or condition resulting in death) /Medical Due to (or as a consequence) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4 Pregnant at time of death s been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 2 □ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b rector, page 2 sh autopsy 2 No 1 ☐ Yes director, 26. Place of Death (Check only 25. Was case referred to medical Be Other: 4 \sum Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 1 ☐ Yes Certification: To After this funeral 27. Manner Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28a. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu death. 2 Accident Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. To the 29d. Date signed (Month, Pay, Year) 29c. License number 29b Signature and title of certifier BXIVE lame and address of person who completed cause of wath (Item 23a)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

21

Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar #29a, per schd, 7/21/09 tj Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Michael Lee Marshall 2009 16 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner alisburg Wicomica Regional Medical Birthplace (State or Foreign Country) If Under 1 Year | If Unde 5. Social Security Number 8. Date of Birth (Month, Day, **Funeral** 219-62-7930 54 11-27-1954 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evancians must be notified at 1 ☐ Yes 2 No Director Somerset Princess Anne 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 30565 Circle Drive 21853 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, I'm Medical Evers in anone. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: 2 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Brick Mason Masonry Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Granville Lee Marshall Agnes Daugherty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 30565 Circle Drive, Princess Anne, MD 21853
Lice of Disposition (Name of Date 20c. Location - City or Town, State Mary Elizabeth Marshall/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Salisbury Crematory 07/18/2009 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, Maryland 22. Name and Address of Facility Hinman Funeral Home Signature of Fune -M00295 11673 Somerset Ave., Princess Anne, MD 21853 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Hepatocellular disease or condition resulting in death) /Medica! Du to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐ No 1 ☐Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Injury at Work? 28d. Describe how injury occurred Aftert 5 Pending investigation 1 🗹 Natural 1 ☐ Yes 2 ☐ No i 24 hours after death. e Funeral Director: A letely filled in by the fu 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier (Check only 2口 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date fled (Month, Day, Year)

100 E. Carroll

within 2 To the

29c. License number

29d. Date signed (Month, Day, Year)

1.16.09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 8:25PM **Physician** 18 JULY **2009** FANNIE HOLLAND O'DONNELL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HARFORD LORIEN BELAIR ASSISTED LIVING BELAIR If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Months Hours Min. 1 M 2 X F 90 NOVEMBER 26, 1918 MARYLAND Director 214-42-9556 Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location show 10a. State 10b. County Examiner must be notified at 1 ☐ Yes 2 No Director **GRASONVILLE** MARYLAND **OUEEN ANNE'S** 10g. Citizen of What Country? 10f. Zip Code 6 UNITED STATES items 23a 1005 CHESTER RIVER DRIVE 21638 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married 'natural", or Specify: WHITE 1 ☐ Yes 2 X No Specify þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) FEDERAL. and 2 should be filed within ealth and Mental Hygiene. n 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 10 SITE HOSTESS GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **GLENNEY MAE WALSTON** ပ MELVIN JACKSON HOLLAND 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 2436 DIXIE LANE, FOREST HILL, MARYLAND 21050 SUE EGAN/DAUGHTER permit. Pages 1 and Department of Healt Important: If item 2: any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition JULY 21, 1 ■ Burial 2 □ Cremation 3 □ Removal from State WOODLAWN MEMORIAL PARK 2009 4 ☐ Donation 5 ☐ Other (Specify) EASTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** END STAGE RHUE UMATOID ARTHRITIS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to minimize the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se's consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 Mo 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? DIABETES 24a. Was an autopsy performed' 1 □Yes 2 🗖 No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ASSISTED Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: al or Attending F s after death. 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

Registrar

Baltimore, Maryland 21215-0036

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Records,

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ANE, IHAVRE DE GRACIE, MD 21078

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** VERNON ODELL OUTTEN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MICOX Pegional Medical Conte toninsula If Under 1 Year 5. Social Security Number Funeral Days 0570371919 Maryland 90 217-36-0010 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Evantmer must be notified at 1 ☐Yes 2 No Director Pocomoke City MD Worcester 10f, Zip Code 10g. Citizen of What Country? 10e Street and Number USA 21851 220 Liberty Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 💢 No Baltimore, Maryland 21215-0036 1 □Yes 2√2 No Specify: White Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Farmer 5 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nora Jones CharlesOutten 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traun once. 220 Liberty Lane, Pocomoke City, MD 21851 Harold Danny Outten/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Nelson's Cem. 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/19/2009 Pocomoke, MD 22. Name and Address of Facility Holloway Funeral Home, P.A. 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD 21851 107 Vine Street, Pocomoke City, Approximate Interval Between Onset and Death Auch Rever Film Immediate Cause (Final **Physician** Duts disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or deriving Cause (Disease or injury Due to (or as a consequence of) Examiner certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) been signed by the a should be detached f 1 ☐Yes 2 ☐ No o 9 Unknown 9 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ My o whis Robert 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown Completed Prin CABG. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 2. No certificate The M Line 1 ☐Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 📉 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Monpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie DYMOBA 1.11.05

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31. Date filed (Month, Pay Year) 2 1 2009

CINDREM

30. Name and addres

32. Registrar's Signature

rson who completed cause of death (Item 23a) (Type, Print)

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-05635 State of Maryland / Department of Health and Mental Hygiene Andrei Pavlovski 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day July 18, 2009 1700 hrs **Medical Examiner** Pavlovski Andrei c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Charles La Plata Civista Medical Center 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 24Hrs. If Under 1 Year 7. Age (In yrs, last birthday) 5. Social Security Number 6. Sex **Funeral** Russia Min. Jan.1,1968 219-47-3610 Months Days Hours Director 1 XM 2 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location Ob. County Silver Spring Yes 2 X No Md Montgomery 28a-f show notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20905 USA Birch Springs Court 14801 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black 12 Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 2 X Married 1 Never Married 2 X No Yes White è Yes 2 X No specify: Specify Yes. Give Year Divorced marked other than "natural", event, the Medical Examiner ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Home Improvements Contractor Baltimore, MD 21215-0036 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Zinaida Vasilievna Pavlovskaya Yuriy Anatolievich Pavlovski Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co2)0905 19a. Informant's Name/Relationship (Type, Print ) it: If item 27 is nother traumatic 14801 Birch Springs Court Silver Spring, Mc Svetlana Pavlovskaya/Wife 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place)
Rock Creek Cem. 1 XBurial 2 Cremation 3 Removal from State 7/21/2009 Washington, D.C. mportant: Other Specify: Donation 5 ure of Funeral S PILTP D. RINALDI FUNERAL SERVICE, P.A. Columbia Blvd. Silver Spring, Md20910 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician Between Onset and failure. List only one cause on each line. /Medical Death a. Coronary Artery Thrombosis Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of) b. Atherosclerotic Cardiovascular Disease Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 brours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical UNPENDED **AMENDED** Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. Part II. Other significant conditions þ 1 Yes 2 No 3 Probably 4 Vunknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 🗸 Yes Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Be Other, examiner? Other: Residence 6 2 V ER/Outpatient 3 DOA Nursing Home 5 Inpatient 1 Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification: 1 V Natural 1 Yes 2 No Pending 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be or Town, State) Suicide (Specify)

OCME

and manner stated

Assistant Medical Examiner 32. Registrar's Signatu

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30. Name and address of person who completed cause of death (Item 23a)

2009

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

July 19, 2009

Registrar

Homicide 29a. Certifier 1

State 31. Date filed (Month, Day Year)

29b. Signature and title of certifie

Melissa Brassell, MD

Medical

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 2009 5:18 Desiree West Petty July/Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Bowie Health Center Prince George

9. Birthplace (State or Foreign Bowie
If Under 24 Hrs 8. Date of Birth (Month, Day, Year July 21, 9. Birthplace (State or Foreign Country) Washington, DC If Under 1 Year 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, **Funeral** Year) Months Days Hours Min. 1 □ M 2 🖼 F 51 577-76-9191 1957 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director Maryland Prince George Bowie 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 1100 Pewter Court 20716 23a United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō Black 1 ☐ Yes 2 🔼 No Specify. Specify: þ 3 Widowed 4 Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within . Department of Health and Mental Hygiene. Important: If item 27 is marked other than "napirjuly or other traumatic event, it e Means injury or other traumatic event, it e Means Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Dohawk ဂ္ Ruth Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William Petty/ Husband 1100 Pewter Court Bowie, Maryland 20716 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Ju1v Harmony Memorial Landover, Maryland 4 ☐ Nonation 5 ☐ Other (Specify) 2009 21. Signal ra 1 Funeral Service Lice 22. Name and Address of Facility Stewart Funeral Home, Inc. MPLEGN 114001 Benning Rd. NE Washington, DC 20019 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in de 1 Physician Lung Cancer 18 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🖾 No Year Month Day 5 Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ HIV Disease cate has been signated by page 2 should b 1 X Yes 2 No 3 Probably 4 Unknown Completed Chronic renal failure on hemodialysis 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2 X No 1 Tyes Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Mother (Specify Health Ctr 1 Tes 2 🔀 No ဂ္ဂ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) DC 18561 July 17, 2009 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) David J. Perry, MD 110 Trving Street NW 20010 Washington, DC 31. Date filed (Month, Day, Year JUL 2 2 2009 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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Physicia		For State 7-22-09Ar egistrar 7-22-09Ar I. Decedent's Name (First, M	mend#1.Pe	erMEOI				-	2. Date of Do	Reg. No eath Day		3. Time of Death
Medical Examin	ner	Lionel W	atts - Po	ELLY				erry Jr.	July 17,	2009	c. County of Death	0015 hrs
¥		ta. Facility Name (if not instit EB 8700 Ritchie M	ution, give street a arlboro Road	nd number			District Hei		101		Prince George	
Funeral	4	5. Social Security Number	6. Sex	7. Ag	e (In yrs. last bi	irthday)	If Under 1 Ye			Birth (MI	M/DD/YYYY) 9. Bir Foreig	thplace (State or
Director	- [	213-02-4364	1 X M 2	F	26	Yrs.	Months   Day	ys Hours M	Aug.	25,		DC DC
•	-	Usual Residence of Deceder			10c. City, Tow	n or Location						10d. Inside City Limits
ow any		10a. State 10b. Cou	ince Geo	rae	loo. oily, row			rict He	iohts			1 X Yes 2 No
aryland 8a-f sh	9 L	Maryland Pr	Thee Geo	IBC	L		10f. Zip Code	1100 110	28	10g. C	itizen of What Cou	intry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show s injury or other traumatic event, the Medical Examiner must be notified at once.	Öire	1908 Roch	nell Ave.	# 1	.521			20747			United	States
h with	Funeral	11. Marital Status 1 X Never Married 2		s Deceden	t Ever in U.S. ?	13. Was	Decedent of H s, specify Cuba	lispanic Origin? ( an, Mexican, Pue	Specify Yes or rto Rican, etc.)	No-	14. Race - Ame White, etc. Afri	rican Indian, Black,
er deat	Fun	3 Widowed 4	Divorced If Yes, G		X No		res 2 X N	o specify:			Specify:Ame 1	
urs afte		15. Decedent's Education	or Dates		mpleted) 16a	a Decedent's	Usual Occup	ation (Give kind fe. DO NOT use	of work done	16b	. Kind of Business	/Industry
72 hor ral Ex	lete	Elementary/Secondary (0	-12) Coli	ege (1-4 or	5+)	gunng mos						
003( within giene.	Completed	17. Father's Name (First, Mi	ridio Last)	4			Social	Worker 18.Mother's Na	me (First, Midd	ile, Maid	Priz en Surname)	rate
21215-0036 Met be filed within 7 Mental flygiene. marked other than cevent, the Medica	Be C		nel Casse	11 Pe	erry, Si	r.			Sonia	Ann	Watts	
212 ould b d Meni s marl	10 E	19a. Informant's Name/Rela									, City or Town, Sta	
Baltimore, MD openit. Pages I and 2 shopertment of Health and Important: If item 27 is injury or other traumati		Sonia A.  20a. Method of Disposition	Watts/ M	lother			ochell ion (Name of o		Date	Hei	ghts, Md.	20747 or Town, State
Ore, ges lau of Hee If ite	П	1 X Burial 2 Crem	ation 3 Rem	oval from S	State cren	natory or other	er place)		July 4, 2009	.   ,	andover	Maryland _
timent riment vor of		4 Donation 5 Oth	er Specify:	٨	Harmo	ony Mei	norial				eral Home	
Ba perm Depa Impo		IL MM IN	W.V.	DION	TY	40	01 Benr	ning Rd.	NE Was	hing	gton, DC	20019
Physician /Medical		2 fa. art I. Enter the disc s fa lure. List only one of	ause on each line.			not enter th	e mode of dyir	ig, such as cardi	ac or respiratory	y arrest,	shock, or heart	Approximate Interval Between Onset and Death
aminer	성 변	Immediate Cause (Final dis or condition resulting in dea			eS sequence of):							1
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	nine	if any, leading to immediate cause. Enter Underlying C (Disease or injury that initial	ause	or as a cor	isequence or,.							
ed nsit	Examine	events resulting in death)	_ast Due to (	or as a cor	nsequence of):							
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760, icate be physic the bur	Physician/Medic	IF FEMALE: 23b. Was decedent pregnar		7	come of pregnar		al death	3 Ectopic pr	eonancv		23d. Date of deliv Month	ery Day Year
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ords, P.O. Box 68760, w requires that the death certificate be ex sheen signed by the attending physician should be detached for use as the burnal.	<u>چ</u>	Part II. Other significant of	onditions contrib	outing to de	ath but not rest	ating in the c	ngerlying caus	se given in r arci				Probably 4 🗸 Unknown
ds, l equires een sig ould be	Completed									Was an autopsy	24b. Were	autopsy findings available to completion of cause of
COF	ם									performe Yes 2	ed? death	1?
ial Recol	ပ္ပိ	25. Was case referred to m	nedical				26.P	ace of Death (Cl	neck only one)			
Vita ysicia this cel	To Be	examiner?	Hospital	l: 1 Inpa		R/Outpatient			lursing Home		esidence 6 🗸 O	ther: Scene
n of Vil ling Physic After this		27. Manner of Death  1 Natural 5	I .	a. Date of ul 17, 200	Injury 2 av Year)	8b. Time of I 0006 hrs	, ,	Injury at Work? Yes 2 ✓ N	Subject	driver		olved in motor
Sior Attend r death ector: by the	catic	2 🗸 Accident	Investigation		f Injury - At hom	ne, farm, stre			28f. Loca	tion (Str	eet and Number or	Rural Route Number, City
Division of Vital Records, piral artending Physician: The law requirers after death erral birectors. After this certificate has been similed in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Homicide	Could not be		Major Road				EB 8700	own, Star Ritchie	te) Mariboro Road	, District Heights, MD
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a Certifier	ing Physician: To al Examiner:On th	the best o	f my knowledge	e, death occu	rred at the time	e, date and place	e, and due to the	e cause(	s) and manner as and place, and due t	stated. o the cause(s)
To the Howithin 24 F. To the Fu	Medical	L 100	and m	e basis of e nanner stat	ed.	nor investiga		cense number			29d. Date signed	
	2	29b. Signature and title of	11	1/	f 0	λ		.C.M.E.	OGME		July 17, 2009	
		30. Name and address of	person who comple	ted cau	of death Item 2	23a)						
CR 9	Ì	Theodore M. Kin		Assistan	t Medical Ex	kaminer		Street, Balti	more, MD 2	1201		
S Regis	state		2009 2	32. Regi	strar's Signature	back						
i real	- 14.				7							

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** July Ž009 Ernest R. Rhoades 1:40 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Upper Chesapeake Medical Center Bel Air, MD Hardford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2-22-1943 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 197-34-0372 66 **Director** Usual Residence of Decedent 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exercity or other traumatic events. Hardford Director MD Abington 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3827 Memory Lane 21009 Apt B Funeral United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🖰 No Specify Specify: White δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) laborer furniture manufacturer 17. Father's Name (First, Middle, Last) Be ( 18. Mother's Name (First, Middle, Maiden Surname) Ernest R. Rhoades, Sr. Emma Jean Ranck ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Brady 1204 Forest Oak Court Bel Air, MD 21015 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cremation Direct Service 7-29-2009 York, PA 17401 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Burg Funeral Home, Inc. 134 W. Broadway Red Lion, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Dissemina 20 week disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner maria 132950 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 □ Yes 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after deat Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of ortifier Hospitalist 29c. License number 29d. Date signed (Month, Day, Year) Uchenaku Nediane 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 UCHENDU UPPER DR BELAIN MD CHESAPEARCE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Dr

1	-	For State Registra

Physicia /Medic Examin

Funeral Director

permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show amy fujury or other traumatic event, it is if wifed Examinating neutroffind at once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

Division of Vital Records, P.O. Box 68760, رحج To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedents Name /First ##1				tificate of l				Reg. No. (	2000	1 2476
1. Decedent's Name (First, Midde Sara Valdes	dle, Last) Reina					2.	Date of Dea Month	Day	Year 2009	3. Time of Death 7:22 p
a. Facility Name (If not institution	on, give street and nu	mber)		4b. City, Town, or	Location of	f Death		<del></del>	county of Dear	
Holy Cross Ho	_	,		Silver	Spri	nα		Mo	ntgome	rv
5. Social Security Number	6. Sex	7. Age (In yrs. las	st hirthday)	If Under 1 Year	_	-	Date of Birtl			thplace (State or Fore
042-32-2549	1 □ M 2 □XF	77	Yrs.	Months Days	Hours	Min.	Date of Birtl (Month, Day arch 2	/, Year)	Co	ountry)
Jsual Residence of Decedent						PI	arch z	0, 1	934 (	Cuba
0a. State 10b. Count	у	10c. City,	Town or Loca	ation						10d. Inside City Lim
										1 <b>∑</b> Yes 2 □ I
	gomery		Silve	r Spring				10a Citiz	en of What Co	ountry?
0e. Street and Number				·				-		outility:
8711 Leonard				20910					SA	
<ol> <li>Marital Status</li> </ol>	Armed Fo		13. W	as Decedent of H Yes, specify Cuba	ispanic Orig ın, Mexican	gin? (Specif , Puerto Ric	ty Yes or No- can, etc.)	. 1	<ol> <li>Race - Ame Black, White</li> </ol>	
1 Never Married 2 Ma	If Yes. Gi		1	Yes 2□No	Specify:		Cuban		Specify:	White
3 Widowed 4 Divorce	d Year or D	ates:								
15. Decede (Specify only high	ent's Education est grade completed)	- 4	(Give k	ent's Usual Occup ind of work done	uring most	of working	- 1	16b. Kin	d of Business	/Industry
Elementary/Secondary (0-12)		I-4or 5+)	life. D	O NOT use retired	0	_				
3			Hou	sekeeper					mestic	
7. Father's Name (First, Middle	e, Last)				18. Mothe	r's Name (F	First, Middle,	Maiden S	Surname)	
Severanio Va	ldes				Ama	ada Ca	atalin	a Re	ina	
19a. Informant's Name/Relation Catalina Carid		Daughter		Address (Street  Leonar						
0a. Method of Disposition			ce of Dispos	ition (Name of	(90)	Date	е	20c. Loc	ation - City or	Town, State
1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (	(Specify)		t Linc	oln Ceme	tery		80 <sup>2</sup>	Bre	ntwood	, Maryland
1. Signature of Funeral Service	e Licensee		F	Name and Addre	. Col	lins 1	Funera	1 Ho	me Inc.	MD 20
500 University Blvd, W., Silver_Sp										
23a. Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List half one cause on each line.  Immediate Cause (Final										
Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Cardiovascular Disease										
resulting in death)  Due to (or as a consequence of):										
Sequentially list conditions	b									
cause. Enter Underlying -	b. Due to	(or as a conse que	ence of):							
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cause. Enter Underlying - Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a conseque	ence of):					2	3d. Date of de	llivery
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Sta Registra

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last 2. Date of Death 3. Time of Death <sup>Day</sup> 2009 **Physician** Anne Marie Rabecs  $A^{\mathsf{M}}$ July 20, 5:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Manor Care Potomac Montgomery Potomac If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 20,1923 Pennsylvania 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) Funeral 1 □ M 2 🖺 F Months Days Hours Min. 86 193-12-4636 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 1 No Directo Maryland | Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10714 Potomac Tennis Lane 20854 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🕅 No Specify. þ Specify: 3 ☐ Widowed 4 🛣 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Federal Elementary/Secondary (0-12) College (1-4or 5+) Secretary Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Stull Helen Cannon 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert N. Rabecs (Son) 4403 Westover Place, N.W., Washington, DC 20016 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State July 25. 4 Donation 5 Other (Specify) Cathedral Cemetery 2009 Scranton, Pennsylvania 21. Signature of Funeral Syrv é Lio ns 22. Name and Address of Facility DeVol Funeral Home, M00689 10 East Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1 Shite the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multiorgan Failure **Physician** Months /Medical Due to (or as a consequence of): Examiner Hypothyroidism Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sician and burial-trans Due to (or as a consequence of): nding physician ause as the burial P.O. Box 68760, certificate be Physician/Medical nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant atten 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year 5 Other (specify) ned by the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Þ Psychosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 第 Unknown Completed Were autopsy findings available prior to completion of cause of death? Osteoporosis 24a. Was an autopsy performed: Dermatitis 2 🔀 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of re Hospital or Attending P n 24 hours after death. re Funeral Director: After t 28c. Injury at Work? After 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D19609. July 20, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10810 Darnestown Rd., Suite 202, Gaithersburg, MD 20878 Tuli, M.D. Raman R. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 21 park

Registrar

Physician
/Medical
Examiner

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Modical Experiment must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit BAZ Sta Registr

	1 - State Registrar	Certificate of Death	Reg. No.	24331
П	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	. Time of Death
an al	EVA JANE RALSTON		07 15 09	2235 M
er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	
	Peninsula Regional Medici	all conter sale	bury Wiconi	CO
	5. Social Security Number 0.14 – 38 – 21.13 6. Sex 1	st birthday) Yrs.  If Under 1 Year   If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (Country) 9. Significant (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Country) 9. Birthplace (Co	(State or Foreign nt
	Usual Residence of Decedent  10a. State 10b. County 10c. City,	Town or Location	10d.	Inside City Limits
ector	MD Worcester Poco	moke City		1√Yes 2□No
ral Dir	215 10th St. Apt. 113	10f. Zip Code 21851	10g. Citizen of What Country?  USA	
Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S Armed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates:	. 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2☐ No Specify:	ncify Yes or No-Rican, etc.)  14. Race - American I Black, White, etc.  Specify: White	= 1
pleted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of workil life. DO NOT use retired)		ry
Com	17. Father's Name (First, Middle, Last)	Bookkeeper/ Cashier	Education (First, Middle, Maiden Surname)	
To Be	Walter Ford		Chambers	
ř	19a, Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Number or Rura		de)
	Sean Ralston/ Grandson	104 Front Street, F	ocomoke City, MD	21851
		metery, crematory or other place) Lisbury Crem. 7/18/	20c. Location - City or Town, 2009 Salisbury, 1	MD
	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Holl 107 Vine Street,	oway Funeral Home	e, P.A. D 21851
	23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition as the death of the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as the condition as t	TOT VEHC BUICCE,	or respiratory arrest, Ap	proximate erval Between set and Death
	Due to (or as a consequence)	ence of):		
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ence of):		
	resulting in death) Last  Due to (or as a consequence)			
Medical				
Completed by Physician/M	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 No  9 ☐ Unknown  23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal in the past 12 No  9 ☐ Unknown	death 3 Ectopic pregnancy	23d. Date of delivery Month Day	y Year
l by Ph	Part II. Other significant conditions contributing to death but not result	ting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the c	32
letec			24a. Was an 24b. Were autopsy	
Comp			autopsy prior to comple performed? death?	etion of cause of
Be	25. Was case referred to medical examiner?  1 D Vos. 2 M No. Hospital: Hospital:	26. Place of Death		
tion: To	1 Tes 2 Autro 1 TA Inpatient 2 E	H/Odipatient 3 DOA 4 Nursing Hot	me 5 Residence 6 Other (Specify) 28d. Describe how injury occurred	
Medical Certification: To	a Electric GE Could not be		28f. Location (Street and Number or Rural Re City or Town, State)	oute Number,
dical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated.	rledge, death occurred at the time, date and place, on and/or investigation, in my opinion, death occurr	and due to the cause(s) and manner as state ed at the time, date and place, and due to the	d. e cause(s)
Me	29b. Signature, and title of certifler	29c. License number	29d. Date signed (Month, Day	; Year)
	· We work	11) DOOG 7758	7/16/09	
	30. Name and address of person who completed cause of death (Item  ALI SABELI MI) 100 E	23a) (Type, Print)  Carroll St. SAL	sbur Ud 21801	•
te ar	30. Name and address of person who completed cause of death (Item  ALI SABELI MI)  31. Date filed (Month, Day, Year)  32. Registrar's Signature and Superior Signature and Superior Signature and Superior Signature and Superior Superior Signature and Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superior Superi	A Sacres	7,	

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	-	For State Registrar		State of M	larylan	d / Depa	artment of F	lealth and N Death		giene Reg. No.	009	24932
Physicia /Medic		1. Decedent's Name	e (First, Middle, Last) Warren Re	emely					2. Date of De Month July	20, Day		3. Time of Death 5:00 A M
Examin			f not institution, give	street and number	)			r Location of Death			ounty of Deat ntgomer	
Funeral		ManorCar  5. Social Security N		x 7. A	ge (In yrs. I	last birthday)	Chevy C	If Under 24 Hrs.	8. Date of Bir	th	9. Birt	hplace (State or Foreign
Funeral Director		192-14-2 Usual Residence of	942	<b>X</b> M 2□F	85	Vro	Months Days	Hours Min.	Sept 9,			nsylvania
ryland how		10a. State	10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 XNo
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a or 2 3a or 2 st be n	Dir	10e. Street and Nur 4821 Boi	nber ling Brool	k Parkway	7	20852				USA		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	11. Marital Status	ied 2□ Married	12. Was Deceden Armed Forces 1 2 Yes 2	t Ever in U.		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🕅 No	Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No o Rican, etc.)		4. Race - Ame Black, Whit	
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Physician		23a. Part1. Enter t shock, or hea Immediate Cause ( disease or conditio	he disease, or comp int failure. List only o (Final in				ter the mode of dyi		or respiratory a	rrest,		Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)		Due to (or a	e to (or as a consequence of): Fected Sacral decubitus ulcer							
uted d ansit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	nditions, nmediate erlying injury s	Due to (or a	ue to (or as a consequence of):  pertension							
be executed ician and burial-transit		resulting in death) I	to (or as a consequence of):									
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The law requires that the death certificate be executed tee has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2 □ 9 □ Unknown	months?	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Feta at time of d	I death 3	□Ectopic pregnanc □ Other <i>(sp</i> ec <i>ify)</i> _	cy		2	3d. Date of de Month	livery Day Year
uires that th signed by t	þ	Part II. Other signi Anemia	ficant conditions co	ntributing to death	but not resi	ulting in the u	nderlying cause gi	ven in Part I.				o the cause of death?
sician: The law require certificate has been sig irector, page 2 should b	Completed								24a. Was auto perf	psy ormed?	prior to death?	utopsy findings available completion of cause of
		25. Was case refer	rred to medical					26. Place of Dea	1□ Yes	2 <b>X</b> No one)	1 ☐ Yes	s 2 No
Physicia this cer al direct	o Be	examiner? 1 □ Yes 2	No	Hospital: 1 ☐ Inpa	tient 2 🗌	ER/Outpatie	nt 3□ DOA Ot		lome 5□Res		□Other (Spe	ecify)
nding Ph th. r: After th e funeral	ation: T	27. Manner of Deat  1 XNatural  2 ☐ Accident	th 5 Pending investigation	28a. Date of Ir (Month, L	njury Day Yea <i>r)</i>	28b. Time o Injury	Wo		28d. Describe			
spital or Attending Pours after death.  eral Director: After tilled in by the funera	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		njury - At ho etc. <i>(Specif</i>		reet, factory, office			(Street and wn, State)		lural Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	Medical C	29a. Certifier (Check only one)	1 Certifying Phy 2 Medical Exam		of examina							
To the within To the Comp	Me	29b. Signature and	title of certifier	Vol	-	MI	29c. Licen D202	se number 274			signed (Mon 20, 20	th, Day, Year) 109
0		30. Name and add	ress of person who c	ompleted cause of	death (Iten	n 23a) (Type,	Print)					

State Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Kirti Vohra, M.D. 771 31. Date filed (Month, Pay, Year) JUL 22 2009

7710 Bradley Blvd. Bethesda, MD 20817
32 Hegistrar's Signature
309 Server S. Sauki

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 9

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Fig. 12   Fig. 2009   \$1.30 PM   March   \$1.00 PM   March   March   \$1.00 PM   March   \$1.00 PM   March   \$1.00 PM   March		Bjs.						2. Date of Death	<u> </u>	3. Time of Death
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Sequentially list conditions conditions are consequence of the consequ		/Medical		disease or condition a.		OSCLETUTIC	- CAPDI	OVASU	LAK PISEAX	2
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29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print)  Mahesha Thimmarayappa MD 614 Easternshore Dr Salisbury MD 21804	o uoi	fe fe		11 Matural 5 Pending (Mont			?	28d. Describe ho	ow injury occurred	
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print)  Mahesha Thimmarayappa MD 614 Easternshore Dr Salisbury MD 21804	Divis	al or Atte s after des al Directo	ertifica	determined 20e. Flace	of injury - At home, farm, s ng, etc. <i>(Specify)</i>	treet, factory, office				ural Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Mahesha Thimmarayappa MD 614 Easternshore Dr Salisbury MD 21804		ne Hospit n 24 hours ne Funera		(Check only 2 Medical Examiner: On the ba	asis of examination and/or	ath occurred at the tim investigation, in my op	ne, date and place, pinion, death occurr	and due to the c red at the time, d	ause(s) and manner as late and place, and due	s stated. e to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Mahesha Thimmarayappa MD 614 Easternshore Dr Salisbury MD 21804		To the within To the comp	Me	29b. Signature and fittle of certifier	-	29c. License	number	2	9d. Date signed (Mont	h, Day, Year)
Mahesha Thimmarayappa MD 614 Easternshore Dr Salisbury MD 21804		10-		Mululun	1 Mi	2 1)	60515		7/17/09	,
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DHMH 17 Rev 1/2001

State

Registrar

JUL 2 1 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 28 2009 11:20 AM July ESTHER PRICE SHAVER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Hours Months August 28. 577-34-3882 83 Washington, D.C. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10h. County 28a-f show event, the Madical Examiner must be notified at 1 □ Yes 2 XINo Director Frederick Frederick Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö 21703 United States items 23a 5769 Box Elder Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 🕱 No Specify. White If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced 'natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) United States is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Administrative Assistant Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Katharine Mason Ernest Price 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 i 5769 Box Elder Ct., Frederick, Maryland 21703 Raymond K. Shaver / Husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date of August 1, permit. Pages Department of Important: If it any injury or or 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Olivet Cemetery 2009 Frederick, Maryland keeney & Basford PA Funeral Home 21. Signature of Funeral Service Licensee 106 E. Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading 1, immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine burial-Due to (or as a consequence of): Box 68760, physician that the death certificate be Physician/Medical the attending 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year ō in the past 12 mg Month Day 5 Other (specify) 2 No □Yes Ö the 9 Unknown 9 Unknown þ ۵. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autonsy perform certificate 2 **12** No 1 ☐ Yes 2 ☐ No 1∏Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 npatient 6 ☐ Other (Specify) Certification: To this Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? After Hospital or Attending 1 Inlatural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide e Funeral I 29a. Certifier 1 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated the

State Registrar

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29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

DIL

Johnson

29d. Date signed (Month, Day, Year)

3 Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signature and title of certifier

Be Completed by Funeral Director

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**Physician** 

/Medical

**Examiner** 

**Funeral** 

For State	State of	iviai ylän(			it of Hea te of De			lental Hygie	0	nno	24	935
Registrar Decedent's Name (First, Middle	a, Last)		Ue.	. ancal	UI DE	-all		2. Date of Death	g. No.	000	3. Time o	
								Month	Day <b>15</b>	Year <b>2009</b>	2:25	P M
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ANNE ARUNDEL	7 40 5			200	NAPOLI	_	= 50001	ı		NNE ARI		
Ocial Security Number		ENIEK 7. Age (In yrs. la	st birthday)	If Under	r 1 Year   If	Under		8. Date of Birth		9. Birth	hplace (State	or Foreig
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Street and Number				10f. Zip	Code			10	g. Citize	n of What Cou	untry?	
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Marital Status	12. Was Deced	dent Ever in U.S ces?	3. 13.	Was Dece	dent of Hispa	anic Ori Vexican	igin? (Sp€	ecify Yes or No- Rican, etc.)	14.	. Race - Amer Black, White		
☐ Never Married 2 🙀 Married □ Widowed 4 □ Divorced	ried 1 ☐ Yes 2	2 💢 No e	1	1 □Yes		Specify:			Sį	pecify: WH		
	nt's Education est grade completed)		16a. Dece	dent's Usu	al Occupatio	n ng most	t of working		6b. Kind	of Business/I	ndustry	
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Fotbode New / /First / 4	Jact) 3							(First, Middle, Ma				
Father's Name (First, Middle, DOYLE W. ANDR					18			MCCONKE				
			104 ***	20 8-2-1	/Stre-					Own Chi	'in Code'	
, informant's Name/Relations EDWARD C . SAN		SRAND		-				IS, MD 2			-p -vue/	
Method of Disposition		20b. Pla	lace of Dispo	osition (Nar	me of	- 1				tion - City or 7	Γown, State	
1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (S	Specify)	itate CHE.	SAPEAR	KE CRI NTER	EMATTO	N	JULY 200	17		ENSVIL		
Signature of Funeral Service	Licensee	***O						N & NEWNA CHESTER				P.A.
a. Part 1. Enter the disease, or shock, or heart failure. List	complications that ca	used the death.	. Do not en	ter the mod	de of dying,	such as	s cardiac c	or respiratory arre	st,		Approxima Interval Be	etween
nediate Cause (Final			ias Guic	v 1	4ccid	ent	-				Onset and	
ulting in death)	Due to (c	or as a conseque	ence of):		,							1
uentially list conditions,	b. N	crebrov or as a conseque the Hod	lakir	7,2	Lyn	ph	rum	<u></u>				
ny, leading to immediate se. Enter Underlying	Due to (c	or as a consequ	ence of):		,	1						
ise (Disease or injury initiated events	с											
ulting in death) Last	Due to (c	or as a conseque	ience of):									
	d											
FEMALE: b. Was decedent pregnant in the past 12 months? 1 Yes 2 100		irth 2 🗍 Fetal ant at time of de	death 3	□ Ectopic p					23	d. Date of deli Month	ivery Day	Year
9 ☐ Unknown 1			Iting in the	nderlying	ause given	n Part '		23e. Did tob	3000 1160	contribute to	the cause of	death?
outer eignineant conditi	on continuumy to de	but not rest.	y in the t	usniyilig (	giveri	art		1 ☐ Yes	-	6		Unknow
								24a. Was an		24b. Were au	topsy findings	
				Plant				autopsy perform	ed2	death?	completion of	availab cause of
						_		perform 1 □ Yes 2	ed? No	death?	2 No	available
Was case referred to medica examiner? 1 □ Yes 2 No	Hospital:	npatient 2 🗆 8	ER/Outpatie	ent 3 D	Other			_ perform	ed? ZWo	death? 1 ☐ Yes	2 No	available cause of

Examiner Be Completed by Physician/Medical Medical Certification: To

**Physician** /Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3m5

State Registrar 29c. License number DS2830

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) July 15, 2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(anine vierney, MD

investigation 6 ☐ Could not be

determined

900 Bestopte Rood #300 Annepolis, MP ZIGOI egnine MD 31. Date filed (Month, Day, Year) 32. Registrar's

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

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ician dical			TE C. S	SANDI								2. Date of D Month JULY	20	-002		3. Time of Death 2:25 A
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DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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Reg. No	Û		9	24	14	3	
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Physicia	ın
/Medic	al
Examin	er

Judith E. Spencer

2. Date of Death
Month
July 21, Day 2009 8:00 A M

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examina must be notified at any injury or other traumatic event, the Medical Examina must be notified at agree.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

State

ner	4a. Facility Name (III		n, give street and no Ridge Dri			4b. City, Town, o Bowie	Death	4c. County of Death Prince George's			e's	
	5. Social Security No. 226–68–0		6. Sex 1 □ M 2 A F	7. Age (In yrs. i	a <i>st birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of E Min. (Month, Jan 2	Birth Day, Yea 4, 1	<sup>r)</sup> 949 V	. Birthplace Country)	(State or Foreign
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ec	MD 10e. Street and Nun		e George's	Bow:	Te	10f. Zip Code			10a. (	Citizen of Wha	at Country?	
Funeral Director			Ridge Dri	ive		20716			US.		ar o o o my i	
nue	11. Marital Status	ad Wil Mar	Armed F	edent Ever in U.s orces? 2 <b>X</b> No	S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origi an, Mexican, I	n? (Specify Yes or I Puerto Rican, etc.)	No-		American In White, etc.	ndian,
	3 Widowed		If Yes, G	ive		1 □ Yes 2 No	Specify:			Specify:	White	
Completed by		cify only highe	nt's Education st grade completed		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most o	of working	16b.	Kind of Busir	ness/Industr	У
Com	Elementary/Secon	ndary (0-12)	College 2	(1-4or 5+)	Owner							ce Compan
To Be	17. Father's Name ( Leo Herb		Last)				18. Mother's Ruth I	s Name <i>(First, Midd</i> Parker	lle, Maide	en Surname)		
	19a. Informant's Na		hip <i>(Typ</i> e. <i>Print)</i>	- Face				or Rural Route Nun				le)
	20a. Method of Disp	position		20b. P		osition (Name of matory or other place		Drive Boy		Location - Ci		State
	1 ☐ Burial 2 🔀 4 ☐ Donation		3 ☐ Removal from Specify)	State				07/22/09	Wo	odbine	, MD	
	21. Signature of Fu	ineral Service	Licensee /	MO MO				ation Servicette, P.				
	23a. Part 1. Enter th	he disease, or	complications that	caused the death							App	proximate erval Between
	Immediate Cause (	(Final		static B	reast	Cancer						set and Death
	resulting in death)		a	(or as a consequ							1	
j.	Sequentially list con	nditions,	b	(or as a consequ	ience of).						_	111111111111111111111111111111111111111
mi mi	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.											
al Ex	resulting in death) L	_ast	Due to	(or as a consequ	ience of):							
edic			d									
Physiclan/Medical Examiner	IF FEMALE: 23b. Was decedent in the past 12	months?	1 Live	utcome of pregna birth 2  Fetal	death 3[	☐ Ectopic pregnand ☐ Other (specify) _	ey			23d. Date of		Year
hysic	1 ☐ Yes 2 € 9 ☐ Unknown	No	9 ☐ Unk		eau St							
	Part II. Other signif	icant conditi	ons contributing to	death but not resu	ulting in the u	nderlying cause giv	en in Part I.			o use contrib 2 ☐ No 3		use of death?
eted												
Be Completed by								24a, Wa au pe	topsy rformed/	pric	or to comple ath?	findings available tion of cause of
Ö	25. Was case refer	red to medica	ı				OG Diago	1 □ Yes of Death (Check onl		No 1L	Yes 2□	INO
ě	examiner? 1 ☐ Yes 2 <b>X</b> ☐		Hospital:	Inpatient 2	EB/Outpatio	nt 3 DOA Oth	041	sing Home 5 X Re		C 🗆 Other	(0	
n:T	27. Manner of Death		28a. Date	e of Injury nth, Day, Year)	28b. Time o		ry at			jury occurred		
catio	2 ☐ Accident	investi	gation			M 1 🗆	lYes 2 □ No					
ertif	4 ☐ Homicide	determ	inod   Zee. Plac	e of injury - At no ding, etc. (Specify	me, tarm, sti	reet, factory, office		281. Location City or 7	own, St	and Number ate)	or Hurai Ho	ute Number,
Medical Certification: To	29a. Certifier (Check only one)		ng Physician: To the Examiner: On the and ma									
Me	29b. Signature and	title of certifie	r			29c. Licens	e number		29d. I	Date signed (	Month, Day,	Year)
		vant	, O. U	reltz		D23743	3		Ju	ly 21,	2009	
	30. Name and address Martin W	Weltz,	M.D. 752	25 Green	way Ce		Greenk	celt, MD :	2077	0		
ite ar	31. Date filed (Mont	th JUL Yeg	2 2009 32.	Registrar's Signa	ture	have						

Registrar

Sparked

awrence Willard S	1-	naffner State of Maryland / Department of Healt For State Certificate of Death		al Hygie		1. No. 2	009 249	3
Physician Medical Examine	1	Decedent's Name (First, Middle,Last) Lawrence Willard Shaffner		I м	ate of Death lonth Ily 15, 20	Day Year	3. Time of Death 2344 hrs	
		,	own, or Location of		., ,	4c. County of Prince Ge		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Unde Months	r 1 Year If Unde s Days Hours	Min.		(MM/DD/YYYY) 6, 1922	9. Birthplace (State or Foreig Country) Washington,	
any	_	Isual Residence of Decedent   10a. State   10b. County   10c. City, Town or Location					10d. Inside City Limits	- 1
Maryland 28a-f show any d at once,		MD Prince George's Upper Marlbon			10	g. Citizen of Wha	1 Yes 2 X No at Country?	4
h the Maryland 3a or 28a-f sh otified at onc		14500 Thorpe Lane	20772			144.5	USA	╛
15-0036 filed within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland but other than "natural", or items 23a or 28a-f sho t, the Medical Examiner must be notified at once		1 Never Married 2 Married Armed Forces? 1 X Yes 2 No 3 X Widowed 4 Divorced If Yes, Give Year 1 Yes 2	nt of Hispanic Orig y Cuban, Mexican, No specify:	, Puerto Rica	/ Yes or No- in, etc.)	14. Race - White, Specify:	American Indian, Black, etc. White	
hours af		15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual during most of work	Occupation (Give I	kind of work	done	16b. Kind of Bus	siness/Industry	٦
5-0036 led within 72 hours aft Hygiene. other than "natural" the Medical Examine		Elementary/Secondary (0-12) College (1-4 or 5+)  11 Machin					Employed	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than e event, the Medica		17. Father's Name (First, Middle, Last) Bert Lawrence Shaffner	Lil	llian	Ann	laiden Surname) Davis		
MD 2121 d 2 should be f lth and Mental n 27 is marked tumatic event,	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address Dale Sorrell (daughter) 615 Carso				ber, City or Towr		1
F te a 3	7	20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition (Nan crematory or other place)	me of cemetery,	July	ate 21	20c. Location -	City or Town, State	
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other tr	-	4 Donation 5 Other Specify: Lee Cremator		200			con, MD Calvert, PA	4
			outhern M	Maryla	nd Bly	vd. Owi	ngs, MD 2073	_
Physician /Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a, Contact Gunshot Wound of Head	or dyring, such as c	ardiac or res	pratory arre	oct, offoot, of from	Between Onset and Death	
caminer	1	or condition resulting in death)  Due to (or as a consequence of):  b.						
ted nisit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated						
xecuted n and I - transit	Exar	events resulting in death) Last Due to (or as a consequence or):					A.I	
50, te be execut ysician and burial - tra	ealca	UNPENDED X AMENDED #1 as noted per ME	G894 8/	5/09 5	rt 	23d. Date of	deliver	_
ox 6876 ath certifical attending ph or use as the	Sician/IN	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  2 Sc. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Spe		c pregnancy		Month	Day Year	
P.O. B es that the digned by the	y Page	Part II. Other significant conditions contributing to death but not resulting in the underlying	g cause given in Pa	art I.			ibute to the cause of death?  Probably 4 Unknown	
ds, P.C	ered r			<del>-</del> [	24a. Was	an   24b. V	Were autopsy findings availab	le
Recor	Completed			·	autop perfo 1 ✓ Yes	rmed?	death?  Yes 2 No	
fital Recsician: The sician: The is certificate irector, page	å n	examiner? Hospital: 4 Inpatient 2 ER/Outpatient 3	26.Place of Death	(Check only Nursing H		Residence 6	✓ Other: Scene	_
Division of Vital Records, pital or Attending Physician: The law require ours after death. Free Thirector: After this certificate has been si filled in by the funeral director, page 2 should be the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the con		27. Manner of Death  Natural 5 Pending  28a. Date of Injury FOWND: FOUND: 1 14.15.2000 28b. Time of Injury FOUND: 287. Time of Injury FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND: FOUND:	28c. Injury at Worl	⊸ İsu	d. Describe bject sho	how injury occurr t self	red	
Division Attender of in by t	Certification:	3 Suicide 6 Could not be determined (Specific) Single Family	y, office building, e		or Town, S		er or Rural Route Number, Cit	у
Divis  To the Hospital or 4 within 24 hours affert  completely filled in b	Medical Ce	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in mand and manner stated.	e time, date and pl y opinion, death o	lace, and due	e to the caus	se(s) and manner	r as stated.	
F.8 F.8	E -		O.C.M.E.	r		July 16, 20	ed (Month, Day, Year)	
		30. Name and address of person who completed cause of death (Item 23a)			04004	1		
dhw 20	fe.	31. Date filed (Month, Day Year). 32. Registrar's Signature	n Street, Baltir	more, MD	21201			- 11
Registr	ar	JUL 21 2009 Jenus S. Sak						

			1 - For AMEND#17perFH, 7-27-09, BMW, MOO Ce Registrar AMEND#4apper MD7-27-09, BMW, MOO Ce	artment of Health and I <i>rtificate of Death</i>	Mental Hygi Re	ene g. No.2009 24939
			1. Decedent's Name (First, Middle, Last)		2. Date of Death	
	Physicia /Medic		Elizabeth C. Terry	<u> </u>	July 18	
	Examin	er	4a. Facility Name (If not institution, give street and number)  ARDEN COURTS  Manor Care Potomac	4b. City, Town, or Location of Death Potomac	1	4c. County of Death Montgomery
armed .	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	0 0
	Director		579-48-3522 1□M 2X F 99 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Nov 3, 19	909 Illinois
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Maryl Ff sho	tor	DC Washingt	on DC		1 XYes 2 No
	th the	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?
	ath wi	ral	4101 Cathedral Ave, N.W. #1008	20016		USA
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is involved.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ▼ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Slif Yes, specify Cuban, Mexican, Puerto 1 □Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
5-0	72 ho 'natur	Completed	(Specify only highest grade completed)	edent's Usual Occupation <u>kind of work done during most of work</u>	king 1	6b. Kind of Business/Industry
121	within ene. <b>than</b>	Jup	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) nemaker		Home
ס	al Hyg other /ent, I	Be C	17. Father's Name (First, Middle, Last)  Callison		ne (First, Middle, M	
ylar	ould be Menta arked aric e	To E	Crosby Wellington Collison	Pearl R	ose Davis	5
Baltimore, Maryland 21215-0036	and 2 sho ealth and n 27 is ma		Darwin Dennis Terry/Son 410	· · · · · · · · · · · · · · · · · · ·	.W. #1008	8 Washington DC 20016
more	Pages 1 Tent of H Int; If iter Iry or oth		1 Li Burial 2 Li Cremation 3 Li Removal from State 1	osition (Name of matory or other place)  L Crematory 7-21		Falls Church, VA
Balti	permit. Departr Imports any inju		21. Signature of Funeral Service Licensee	2. Name and Address of Facility $f J_{08}$ $f 5130$ $f Wisconsin$ $f Ave$	seph Gawl e, N.W. W	er's Sons,INC ashington DC 20016
			23a. Part 1. Enter the disease or complications that caused the death. Do not en shock, or heart failure. Ast only one cause on each line.			st, Approximate Interval Between
C. C.	Physician	ő á	Immediate Cause (Final disease or condition Alzheimer's Demen	tia		Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):			
	8	ıer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
>	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Entire Unidentifying Cause (Disease or Injury that initiated events c.			
90,	ificate be executed g physician and ss the burial-transit		resulting in death) Last Due to (or as a consequence of):			
68760,	ficate physi s the t	edical	d			
O. Box	attending for use	Physician/Me		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
s, P	w requires that the d been signed by the should be detached	by Pr	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	acco use contribute to the cause of death?
ord	equire sen siç ould b	ted t			1 □ Ye	s 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
Division of Vital Record	: The law r cate has b page 2 sh	Completed			24a. Was an autopsy perform 1 🗆 Yes 2	prior to completion of cause of
Ĭ;	sician; Th certificate rector, pag	Be	25. Was case referred to medical examiner?  Hospital: Hospital:		ath (Check only one	
of	g Physer this	n: To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at Work?	lome 5 ☐ Reside 28d. Describe ho	nce 6  ☐Other (Specify) w injury occurred
ion	eath. or: Aftu he fun	atio	1 ∰ Natural 5	M 1 ☐ Yes 2 ☐ No		
Divis	al or Atte s after de l Directo ed in by tl	Certification: To	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office	28f. Location (Str City or Town	eet and Number or Rural Route Number, , State)
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical (	29a. Certifier (Check only one)  1X Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or and manner stated.			
	To th Withii To th COMP	Me	29b. Signature and title of certifier	29c. License number	29	Dd. Date signed (Month, Day, Year)
	10		Shamer R. Mittal My	D0061382		July 20,2009
			30. Name and address of person who completed cause of death (Item 23a) (Type Shama R. Mittal, MD, 14816 Physician	s Lane, #152, Rocl	kville, M	D 20850
	Sta Registr		31. Date filed (Month, Day, Year)  JUL 21 2009  Service for the signature.	Kal		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 9A M Gladys В. Taylor 2009 JUI 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Lanham Doctors Hospital Prince George Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Min. Months 1 □ M 2 🕅 F 578-42-8436 March 26, 1923 South Carolina 86 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 1 Yes 2 □ No Suitland Maryland Prince George 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 20746 United States # 203 2310 Ewing Ave Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ∏Yes 2 TNo 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Dietician Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Barnes Sr. Corrine Gillespie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20774 Patricia Taylor/ Daughter 10155 Campus Way Largo, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington National 23, 2009 Suitland, Maryland o Funeral Service Lice see 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd. NE Washington, DC 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Jause (Final Due to ( as a consequence of): disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 **X**No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4- Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2 🔀 No 1 ☐ Inpatient 2 🛣 ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 💢 Natural 5 Pending 1 □Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide

Hospital or Attending Physician: The law requires that the death certificate be executed 14 hours after death.

Funeral Director: After this certificate has been sinned by the advantage. burial-trar Division of Vital Records, P.O. Box 68760, the 24 hours a

**Physician** 

**Examiner** 

**Funeral** 

Director

T is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exprinent mast be retified at

filed within 72 hours after death with the Maryland

12 should be filed within h and Mental Hygiene. 7 is marked other than

permit. Pages 1 and 2 Department of Health a Important; If item 27 is any injury or other trau once.

**Physician** 

/Medical Examiner

21215-0036

Maryland

Saltimore,

/Medical

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Completed

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Certification: To

Medical

29a. Certifier

(Check only one)

State Registrar

and manner stated

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier ille

MDD30858

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GOOD LUCK ROAD, LANHAM, 01400

31. Date filed (Month, Day, Year) 2 2 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2009 Mary Louise Twigg 17. July 10:05 PM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Montgomery Casey House Rockville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Aug 4, 1951 9. Birthplace (State or Foreign Days 1 □ M 2 🗙 F Mary Land 57 214-46-2819 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8603 Victory Lane 20854 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 □Yes 2 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert G. Hill Marie Dreyer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) H. Glenn Twigg, Jr. /husband 8603 Victory Lane Potomac, MD 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Final Journey Crematory 07/21/09 Woodbine, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Li 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784 MO1251Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ovarian Cancer Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of) 23d. Date of delivery death 3 Ectopic pregnancy Month Year Day

**Physician** /Medical Examiner

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attending physician

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e Funeral Director: Albetely filled in by the fi

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permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Magnes.

**Physician** 

Examiner

**Funeral** 

Director

ed other than "natural", or items 23a or 28a-f show event, the Wedical Exactions to profiled at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

10a State

MD

Director

Funeral

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Completed

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Examine Physician/Medical þ Completed Be Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter the carrying Cause (Disease or injury that initiated events resulting in death) Last 23

3 Suicide

29a, Certifier (Check only one)

4 Homicide

FEMALE:  b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of deady 9 ☐ Unknown
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5 Other (specify)

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 █ Unknown 24a. Was an autopsy performe 1 □ Yes

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 🗆 No

25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 X Natural 2 Accident 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Kother (Specify) hospice 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 1. Kouce

6 Could not be determined

29c. License number D 63748

29d. Date signed (Month, Day, Year) July 19, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jocelyne Kouatchou, M.D. 6001 Muncaster Mill Rd. Rockville, MD 20855

State Registrar 31. Date filed (Month, Day, Year)

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMMENDED 07/28/2009 FCHD Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** July 2009 BERNARD HERBERT VANMETER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick
| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Frederick Memorial Hospital Birthplace (State or Foreign Country) 6. Sex 1 M 2 □ F Age (In yrs. last birthday) **Funeral** 186-44-0051 56 Yrs. West Virginia Nov. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or intems 23a or 28a-f show any or other traumatic event, the Medical Examinar must be righted at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes X☐ No Director Maryland Frederick Adamstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21710 5833 Aberdale Place United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 K Yes 2 □ No 1975 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Yes Give Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) +4 Water Plant Operator Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bernard F. VanMeter Zoe Leatherman ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Raylene Kershaw Raylene VanMeter / Wife 5833 Aberdale Place, Adamstown, MD 21710
Date Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of F
Important: If ite
any Injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 7/18/2009 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Memorial Frederick, Maryland 21. Sig At re of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fature. List only one cause on each line. However, the condition of the cause of condition are proposed in the cause of condition. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 70 Years **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to for as a consequence of If any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed burial-trar Due to (or as a consequence of): physician a Box 68760 Physician/Medical requires that the death certificate attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) o 1 ☐ Yes 2 ☐ No. 9 Unknown 9 Unknown ed by 1 detach σ. been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law page 2 s has autopsy performed? 1 ☐ Yes 2 No certificate 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 →No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number

25 15 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johnson Dr. Frederick, MD

Registrar

KranT2

80

32. Registrar's Signat

2. Date of Death

3. Time of Death

2125

Birthplace (State or Foreign Country)

10d. Inside City Limits No Yes 2 No

20011

2009

	/Medic		Luke	Wright				July	12	2009	2125
	Examir		4a. Facility Name (If not institution, g.	ive street and number)		4b. City, Town, o	r Location of D	eath	4c. Cour	nty of Deat	th
			Prince Georges I 5. Social Security Number 6.	Hospital		Cheverly				ce Ge	orges
	Funeral		·	INFIRM OF F	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours N	Ain. (Month, D	rth a <i>y, Year)</i>	9. Birt	thplace (State or For ountry)
	Director		256-28-7334	85	YIS.			March	1, 1924	+ N.	Carolina
	put *		Usual Residence of Decedent  10a. State 10b. County	10c Gi	ty, Town or Lo	ation					10d. Inside City Lin
	aryla sho	ក									Na Yes 2□
	he N 28a-1	Director	DC 10e. Street and Number	Wash	ington	10f. Zip Code			10g. Citizen o	of Mihot Co	Luntar?
	a or	ä							-	JI WIIAL CO	unity:
	s 23	eral	43 T Street N		0 140.1	2002	lianania Osiais	2 (Consity Van ex N	USA	loss Ame	erican Indian,
	er de item	Š	11. Marital Status	12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 🖾 No	.5.	Yes, specify Cub	an, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	)- 14. h	Black, White	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaning must be notified at once.	d by Funeral	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		□Yes 2≹ No			Spe	RTa	
5-	"natu	ete	15. Decedent's E (Specify only highest g	Education rade completed)	16a. Deced	lent's Usual Occup kind of work done OO NOT use retired	oation during most of	working	16b. Kind of		•
212	d within giene. er than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	1	ail Cler			U.S. Feder	Posta al Gc	al Service overnment
b	e file al Hy l oth	Be (	17. Father's Name (First, Middle, Las	ot)				Name (First, Middle		•	
<u> a</u>	uld b Ment Irked Itic e	ဥ	William Wright				Eliza	beth Blac	ckshear		
a	sho and sums		19a. Informant's Name/Relationship	(Type. Print)	19b. Mailin	g Address (Street	and Number o	r Rural Route Numb	oer, City or Tov	vn, State, 2	Zip Code)
Σ	and 2 salth n 27 i	l, ,	Louise Wright/V	Vife	43 7	Street	N.E. V	Washington	n,DC 2	20002	
ore.	of He		20a. Method of Disposition	20b. F	Place of Disponent	sition (Name of natory or other plac	ce)	Date	20c. Locatio	n - City or	Town, State
Ĕ	Page nent int: II		1 ☑ Burial 2 ☐ Cremation 3 I 4 ☐ Donation 5 ☐ Other (Spec	_ Hemovai from State		Nationa		g. 7,2009	Arling	ton,	VA
ati	partr ports / injt		21. Signature of Funeral Service Lice	ensee	22	. Name and Addre		Latney's			
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3,092	Physician Associated Associated Physician Associated Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physician and Physi	cal Examiner	shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	uence of);	pohe (	(AR)	10VA-SCI	Vas Di	Sag	Onset and Death
P.O. Box 68760,	ires that the death certificate be executed signed by the attending physician and it be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnant 2 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 death 5	Ectopic pregnance Other (specify)		220 Did		Date of del	Day Year
ords,	The law requires that ate has been signed t page 2 should be deta	<u>م</u>	Part II. Other significant conditions ESOphageal		-		en in Part I.		Yes 2 □ No	3 □ Pi	o the cause of death'
Division of Vital Records,	uing Physician: The law h. After this certificate has b funeral director, page 2 st	Completed						— 24a. Was — auto perf 1 ∐Yes		<ul> <li>b. Were au prior to death?</li> <li>1 ☐ Yes</li> </ul>	utopsy findings availa completion of cause s 2 □No
Vita	Attending Physician: Thr r death. ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Laggistic		la:		Death (Check only	one)		5-10000000
- JiC	Phys this al dir	ဥ	1 Yes 2 No	Hospital: 1 Inpatient 2			4 LI Nursii	ng Home 5 ☐ Res		<u> </u>	ecify)
<u>_</u>	ding F	ü.	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Wor		28d. Describe	how injury occ	urred	
<u>Si</u>	tend leath tor: / the fi	cati	2 Accident investigation 3 Suicide 6 Could not				Yes 2□No				
Divi	afte Dir Iin I	Certification: To	4 Homicide determined	28e. Place of Injury - At he building, etc. (Special	ome, farm, stre fy)	eet, factory, office		28f. Location City or To	(Street and Nu. wn, State)	mber or Ru	ural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical (	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exa	Physician: To the best of my known aminer: On the basis of examination and manner stated.	owledge, death ation and/or in	occurred at the ti vestigation, in my o	me, date and popinion, death	place, and due to the occurred at the time	e cause(s) and e, date and plac	manner a	s stated. e to the cause(s)
	To the within To the Comple	Ž	29b. Signature and title of certifier	1		29c., Licens	se number		29d. Date sig	ned (Mont	th, Day, Year)

For State Registrar

1. Decedent's Name (First, Middle, Last)

acco use contribute to the cause of death? 2 No 3 Probably 4 Onknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

(Month, Day, Year)

State Registrar

			State of Maryland / De 1 - State AMEND#24a/bperMD, 7-23-09, BW, Moco Registre AMEND#7 per FH7/21/09, BW, Moco	partment of Health and I Certificate of Death	Mental Hygid Reg	ene 3. No. 2009	24944
	Physici /Medio		1. Decedent's Name <i>(First, Middle, Last)</i> Mary Julia Webb		2. Date of Death Month July 14,	Day Year 2009	3. Time of Death  11:50 M
	Examir		4a. Facility Name (If not institution, give street and number) 6101 Clinton Way	4b. City, Town, or Location of Death		4c. County of Death Prince Geo	
	Funeral Director		5. Social Security Number  6. Sex 1 M 2 F 7. Age (In yrs. last birthd 72 Yrs	ay) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Y		lace (State or Foreign
	aryland show	ı	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location			0d. Inside City Limits
	vith the Mi	Director	Maryland Prince Georges Clinton  10e. Street and Number	10f. Zip Code	10g	g. Citizen of What Cour	1 € Yes 2 □ No
	ges 1 and 2 should be filed within 72 hours after death with the Maryland if of Health and Mental Hygiene. If the m Z1 is marked other than "natural", or items 23a or 28a-f show of other traumatic event, the Medical Examinar must be notified at	Funeral	11. Marital Status  1 □ Never Married 2 □ Married 1 □ Yes 2 ⋈ No	20735  3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
21215-0036	2 hours al	Ď	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates:  15. Decedent's Education 16a. De	1 □ Yes 2 1 No Specify:	16	Specify: B1ac	
21212	ed within 7 ygiene. er than "r t, the mad	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done during most of work e. DO NOT use retired) d Service	ing	Private	
Maryland	2 should be file and Mental Hy is marked oth aumatic event	To Be	17. Father's Name (First, Middle, Last) Irving Leon Johnson	18. Mother's Nam LIllian	e (First, Middle, Ma . Brown	aiden Surname)	
	1 and 2 sho Health and tem 27 is m			ailing Address (Street and Number or Ru $1$ ${ t Clinton}$ ${ t Way}$ ${ t Clin}$	,	City or Town, State, Zip Land 20735	Code)
_	Pages 1 a nent of Hea int: If item iry or othe		20a. Method of Disposition 1	sposition (Name of rematory or other place)	Date 20	c. Location - City or To	
Baltir	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee	n Cemetery   7-21 22. Name and Address of Facility  Latney's Funeral Ho	3831	rnham, Virg Georgia Av ington, D.	enue, N. W.
	hysician		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arres	at,	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)  a. Due to (or as a consequence of):	hronic Obstructive	ethi	y conuce_	10 746s
,	ecuted and transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.				
58760,	ricate be executed physician and s the burial-transit	edical E)	Due to (or as a consequence of):				
. Box	eath certi attending for use a	Physician/Me		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive	ery Day Year
7.	v requires that the dispersion is been signed by the should be detached	by Phy	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobac	cco use contribute to the	e cause of death?
Records,	as been s				1 ☐ Yes 24a. Was an		ably 4 ☐ Unknown  osy findings available
_ F	ate h	e Completed	25. Was case referremedical	20.00	autopsy performe 1 □ Yes 2 <b>X</b>	prior to cor	npletion of cause of
5	th.  After this certificate funeral director, pag	10 B	examiner? 1   Yes 2   No	tient 3 DOA Other: 4 Nursing Ho		ce 6 🗆 Other (Specifi	)
DIVISION	Attending ir death. ector: After by the fune	Certification:	1 Natural 5 ☐ Pending (Month, Ďay, Year) Injur 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	y Work? M 1 □ Yes 2 □ No	28d. Describe how	injury occurred	
מוא	To the nospiral of Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fun	Certif	4 Homicide determined building, etc. (Specify)		City or Town, S		
100	in 24 hou he Fune pletely fi	Medical	29a. Certifier  (Check only one)  1  ✓ Certifying Physician: To the best of my knowledge, de 2  Medical ExamIner: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place, r investigation, in my opinion, death occur	and due to the cau red at the time, date	ise(s) and manner as s e and place, and due to	tated. the cause(s)
, t	3 E E E E	Σ	29b. Signature and title of certifier	29c. License number  D 006 6719		Date signed (Month, I	
	9	-	30. Name and address of person who completed cause of death (Item 23a) (Typ		1. Int day	2 140 20	603
2	Stat Registra	_	31. Date filed (Month, Day, Year)  JUL 21 2009  June 5. 4	all	co ac cor	p ~ 00 20	

			1 - For Amend Items State Registrar  1. Decedent's Name (First, Middle		, 25 , 2	21,28a-1	per me, ertificate	of De	oath	2. Date of De		200	9 2 L	945 Death
Phys /Me	icia dica			Wellen						Month	Day	Year 2009		P <sup>M</sup>
Exar	mine	er	4a. Facility Name (If not institution						cation of Death		4c. C	County of Dea		
Francis		-	Northampton Mar  5. Social Security Number	nor Nursi		lome (In yrs. last birtho		reder Year   If	Cick Under 24 Hrs.	8. Date of Bir	th	Frede	rthplace (State o	or Foreign
Funer Direct			220-28-3943	1 □ M 2 🖾 F		76 Yrs	Months	Days F	Hours Min.	(Month, Da	ay, Year)		ountry) aryland	
nd.			Usual Residence of Decedent  10a, State 10b, County			10- Oity Town	. I a a stia a						10d. Inside Ci	tu Limita
laryla f shov		ē				10c. City, Town or							1 □ Yes	,
the N		Director	Maryland Wash: 10e. Street and Number	ington		Kn	oxville 10f. Zip C	ode			10a, Citiz	en of What C	ountry?	
h with 23a or			19644 Yarrowsbu	ırg Road				2175	8			ed Sta	-	
15-UU36 n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show		by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Marr  3 □ Widowed 4 □ Divorced	12. Was De Armed F 1 ∐Yes If Yes, 0 Year or	Forces? 2 □ N Bive	ver in U.S.	3. Was Deceder If Yes, specifing		anic Origin? (Sp Mexican, Puerto Specity:	ecify Yes or No Rican, etc.)		4. Race - Am Black, Whi Specify: Wh		
5-0036 72 hours aff hatural", or		ted	15. Deceden	t's Education	n	16a. De	ecedent's Usual	Occupation	n		16b. Kin	d of Business	s/Industry	
within 7 iene.	ľ	Completed	(Specify only highest Elementary/Secondary (0-12)	T	<u>')</u> (1-4or 5+	+) lii	ive kind of work ie. DO NOT use	retired)		ing		7 1/	<i>c</i> ,	
D 00 0			12. Father's Name (First, Middle,	( act)		Ор	tical I		. Mother's Name	/Eirot Middlo			nufactui	ring
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re, Maryls s 1 and 2 should if Health and Mer Item 27 Is marke other traumatic			19a. Informant's Name/Relations Robert Wellen		ı		ailing Address (8 44 Yarr				-			
Ore, IVI		1	20a. Method of Disposition	ilusballo		20b. Place of Di				Date			r Town, State	
timo t. Page rtment o rtant: If			1 ☐ Burial 2 🖾 Cremation 4 ☐ Donation 5 ☐ Other (S	pecify)	n State		en Crem	atory	7 2	17,			Maryla	nd
Dermi Depa Impo	ouce		21. Signatur Funeral Service	ensee			Resthav 9501 Ca							
Physicia	in		23a. Part 1. Enter the disease or shock, or heart failure. List Immediate Cause (Final diseas or condition	complications that	caused each line	the death. Do not e.	. 4		such as cardiac		ırrest,		Approximate Interval Bet Onset and I	ween
/Medica	_		resulting in death)	Due to	o (or as a	consequence of):					,,	1	, , , , , ,	
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Duc to	UF as a	eorisequenes of):			0	1	EVAMIL	NER		
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of bu, cate be executed obysician and the burial-transit														
c bb ertifical ing phy e as th		Medi	IF FEMALE:	11							1			
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as t		Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown		birth a	of pregnancy 2 ☐ Fetal death time of death	3 ☐ Ectopic pre 5 ☐ Other (spec				25	3d. Date of de Month		/ear
s that	i		Part II. Other significant condition				e underlying cau	se given ir	n Part I.	23e. Did t	tobacco us	e contribute	to the cause of d	eath?
VII.dal HECOIGS,  ician: The law requires t certificate has been signe ector, page 2 should be o		ted by	LEFT H	IP FR.	ACT	NNE				1 🗆	Yes 2	No 3□ F	Probably 4 🗆 l	Jnknown
Hec The law te has b		Completed								24a. Was auto perfo	psy prmed?	prior to death?		available ause of
ltar ian: ] ian: ] rtiffica ttor, p		a i	25. Was case referred to medical					26	6. Place of Deatl	1 ☐ Yes		1 ☐ Ye	s 2 LINo	
hysic his ce I direc		9 .	examiner? 1 X Yes 2 No	Hospital: 1	] Inpatier	nt 2 🗆 ER/Outpa	tient 3 DOA	O41	4 Nursing Ho			☐Other (Sp	ecify)	
Attending Physic death.  **Rector: After this by the funeral care.		ö	27. Manner of Death  1		e of Injur hth, Day,	y 28b. Tim Four	e of 280 <b>vd: a</b> <sub>M</sub>	lnjury at Work?		28d. Describe			of bed	
ttend death ctor: / the f		ertification:	2 Accident investig 3 ☐ Suicide 6 ☐ Could r	othe UIII.		U9 Unkno	)Wn '''	1 ☐ Yes						
after Direct din by			4 Homicide determ			ry - At home, farm, . <i>(Specify)</i> <b>g Home</b>	Street, factory, c	mice	,	City or To	wn, State) ck MD	200 E.	Rural Route Num 16th S	treet
Hospita 24 hours Funeral		Medical	29a. Certifier 1 Certifyin (Check only one) 2 Medical	g Physician To the	ne best o	f my knowledge, d examination and/o	eath occurred at r investigation, i	the time, n my opini	date and place,	and due to the	cause(s)	and manner	as stated, ue to the cause(s	)
To the within To the comple	2	Me	29b. Signature and title of certifier	1////				License nu			29d. Date	signed (Mor	nth, Day, Year)	
			1/6	Mell	_	20.		126	499		フー	-17-	09	
0			30. Name and address of person Ronald Miller,			Box 210,		y, M	D 21771					
	State	-	31. Date filed (Month, Day, Year)	32.	Registra	r's Signature								
Regi			JUL 20	2009	BABLE	~ B.	parker							
DHMH 17 Rev	1/200	/ 1		/			RIGINAL							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2:30 PM CARROLL WILKERSON JULY 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE SAMARITAN HOSPITAL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** 1**X** M 2 □ F Months Days Hours 214-52-9723 Director JAN. 23,1949 MARYLAND Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location show 10d. Inside City Limits event, the Medical Exeminar must be notified at MD Director BALTIMORE 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1646 LOCKWOOD RD 21218 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 2/67,71 1 Never Married 2 Married Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or any injury or other traumatic event, the "sector I Eventangones. 1 □Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 MECHANIC PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HERBERT C. WILKERSON IDA A. TASKER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TRACEY WILKERSON/DAUGHTER 7926 ALLARD CT., #303 GLEN BURNIE, MD.21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages ' 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD. VET. CEMETERY | 7/24/09 4 ☐ Donation 5 ☐ Other (Specify) CROWNSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CAPITOL MORTUARY 1425 MARYLAND AVE., NE WASHINGTON, DC20002 or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Part 1. Enter the dis as shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final Physician METASTIC disease or condition resulting in death) COLON /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 2 No 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No after death Director: filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) the

Registrar

State

29b. Signature and title of certifie

MODICAL

32. Registrar's Signature

SAMARITAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GOOD

ATTONDING

29c. License number

200 62239

MAW NAING OO, MD

18 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month Physician 2009 July 15, Beulah Walker /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Bradford Oaks Nursing Home Prince George Clinton 8. Date of Birth (Month, Day, Year) Feb. 18, 1 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral Months Days Hours Min. 1 □ M 2 🔀 F 1916 South Carolina 93 Yrs Director 579-66-0613 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expression in the natified at once. 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 X Yes 2 □ No Director Maryland Prince George Clinton Clinton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20735 7520 Surratts Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 1 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Black 1 ☐ Yes 2 🖾 No Baltimore, Maryland 21215-0036 Specify: Specify: ģ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Domestic Worker 6th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Julia Allen Willie Hampton ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20019 Edna Gordon/ Sister 4502 Foote Street NE Washington, DC 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 23, 2009 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Washington National 22. Name and Address of Facility Stewart Funeral Home, Inc. f uneral S vice lice 21. Signatu 4001 Benning Rd. NE Washington, DC Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or peart failure. List only one cause on each line. Immediate Cause (Final 5 years **Physician** Dementia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Atherocelerosis Cardiovascular Disease 10 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Year in the past 12 months? 5 ☐ Other (specify) . Tyes 2 No signed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 X No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 26. Place of Death (Check only one) completely filled in by the funeral director, Be 25. Was case referred to medical examiner? Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 XNo Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death Certification: After (Month, Day, Year) Injury 5 Pending 1 X Natural 1 □Yes 2 □No death. investigation after death Director: 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical To the I within 2

State Registrar

31. Date filed (Month, Day, Year) JUL 2 2 2009

29b. Signature and title of certifier

Michael G. Sidarous, M.D. 11701 Livingston Rd. # 101 Fort Washington, Md. 32. Registrar's Signature rack

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

MD 745365

29d. Date signed (Month, Day, Year)

July 17, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24948 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 11:43P M **Physician** Richard Tolliver Watkins 2009 Ju1y 14 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Bethesda Montgomery National Institutes of Health If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 X M 2 □ F Yrs. 1954 579-78-0083 24, DC Director 54 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wolcal Evant necessary be notified at once. 10b. County 10c. City, Town or Location 1 Yes 2 □ No Maryland Montgomery Potomac 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10702 Stable Lane 20854 United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: African 1 Tyes 2 No Specify: b 3 Widowed 4 Divorced American Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) VP Sales F Consulting Federal Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Naomi Tolliver Charles Watkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Ronnie Watkins/ Wife 10702 Stable Lane Potomac, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harmony 20a. Method of Disposition Date 20c. Location - City or Town, State July 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Landover, Maryland <u>Memorial</u> 22. Name and Address of Facility 21. Signature of Funeral Service License Stewart Funeral Home, Inc. 4001 Benning Rd. NE Washington, DC Approximate Interval Between Onset and Death 23a. Part 1. Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pulmonary My Immediate Cause (Final **Physician** ears disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 Tes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun-Natural 2 Accident 5 Pending 1 Tyes 2 🗆 No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ical (Check only one) and manner stated 29b. Signature and title of certified D0068295

CR 20

State Registrar 31. Date filed (Month, Day, Year)

ason

(Year) 32. Registrar's Signature

on who completed cause of death (Item 23a) (Type, Print)

10 Center Drive, Bethesda, MD 20892

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Pearl Month **Physician** Irene Yamamoto July 17, 2009 5:27 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 🛣 F **Director** 283-30-7772 73 23, 1936 Ohio Jan. Usual Residence of Decedent the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 ₩ No Directo California San Bernardino Ontario 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö items 23a 642 Humboldt Court 91764 USA Funeral death y 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. \$ Specify: White 3 → Widowed 4 □ Divorced Completed event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ OR Technician Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evonce. Oral Eldon Smith Elsie Elizabeth Reed ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Amy Coll/Daughter P.O. Box 486, Whittier, CA 90608 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 N Removal from State Riverside National July 21, Riverside, California 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign were if Funeral Service Licenses 22. Name and Address of Facility Francis J. Col 500 University ins Funeral Home Blvd. W., Silver Inc. Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions or cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) been signed by the a should be detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy certificate 1 ☐ Yes 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After Natural 5 Pending investigation ours after death. neral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 2 To the I and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of D64296 July 17, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard Nguyen, MD 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUL 21 Registrar

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 95 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 Year July 18, 0430 Wallace Baldwin Young 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 6. Sex 1 X M 2 ☐ F 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 142-36-4818 61 2/14/1947 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1X Yes 2 □ No Temple Hills MDPrince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20748 3001 Branch Avenue, #411 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Telephone/ Elementary/Secondary (0-12) College (1-4or 5+) Technician 12 Communication 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick Young Georgie Beverly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mattie B. Young/Wife 1477 Newton St., NW, #105, Wash., DC 20010 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other ( 3 Removal from State Westdeptford, NJ 5 ☐ Other (Specify) Woodbury Memorial 07/25/2009 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD 20748 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoo, or heart failure. List only one cause on each line. Immediate Cause (Final Vietostati disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IE EEMALE

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

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Physician/Medical

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**Funeral** 

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Opertment of Health and Mertal Hygiene. Important: If the 23s or 28sf show Important: If the 27s is marked other than "natural", or items 23s or 28sf show any Injury or other traumatic event, its Marital Exemine in all to in Illia I at

18/09 じがろし altimore, Maryland 21215-0036

physician and s the burial-tran attending p

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Records,

Vital

cate has been signed by the page 2 should be detached Medical Certification: To Be Completed e Hospital or Attending Pl 24 hours after death. e Funeral Director: After the fulled in by the funeral within 24 hours a

To the Funeral D

23b. Was decedent printhe past 12 mo 1 ☐ Yes 2 ☐ N 9 ☐ Unknown	onths?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fets 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 🗆 Ecto	oic pregnancy r (specify)			23d. Date of delivery Month Day Year
Part II. Other significa	ant conditions c	ontributing to death but not res	sulting in the underlyi	ng cause given	in Part I.		o use contribute to the cause of death?  2 No 3 Probably 4 Unknown
						24a. Was an autopsy performed?	
25. Was case referred examiner?				2	6. Place of Dea	th (Check only one)	
1 Yes 2 No		Hospital: Inpatient 2	ER/Outpatient 3	DOA Other	4 Nursing H	ome 5 Residence	6 ☐ Other (Specify)
2 Accident	5 ☐ Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury a Work? 1 □Ye	s 2 □No	28d. Describe how in	jury occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, faity)	ctory, office		28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
29a. Certifier 1 (Check only 2 one) 2	Certifying Ph Medical Exam	ysician: To the best of my known inner: On the basis of examination and manner stated.	owledge, death occu ation and/or investiga	rred at the time	, date and place nion, death occu	e, and due to the cause erred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and titl	e of certifie			29c. License i	number	29d. [	Date signed (Month, Day, Year)
1	5	MD		D66	304	٥	7/18/2009

State Registrar

31. Date filed (Month

Sujoy Ghosh Tagore,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8600 Old Georgetown Road, Bethesda, MD

20814

State of Maryland / Department of Health and Mental Hygiene 🤈 🗎 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 9:15 PM Kimberly Ann Apalucci /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Seasons Hospice Randallstown Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 □XE Director 216-88-8220 48 Sept. 29, 1960 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner nust be notified at 1 ☐ Yes 2 1 No Director Maryland Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21136 USA 'natural", or items 23a Funeral 4 Craftsman Court within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Completed by Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerical Financial 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Jacob Watts Gwendolyn Matilda Snyder 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Watts, Jr. Brother 1800 James Circle; Titusville, Florida 32780 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 8/5/2009 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licens 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a unsequence of): **Physician** /Medical Examiner Aspiration Se uentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed Sician and burial-trans Due to (or as a consequence of) Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 📉 No Month 5 Other (specify) P.O. detached signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed + Plespiratory Distress Syndrome 24b. Were autopsy findings available prior to completion of cause of death? autopsy or Attending Physician: The performe Ischemic 1 ☐Yes 2 No funeral director 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending within 24 hours after death.

To the Funeral Director; A investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifiei completely (Check only one) completed cause of death (Item 23a) (Type, Print) from Sule 203 Baltmare MD 21209 2835 1)6bmah 31. Date filed (Month, Day, Year) 32 Registrar's Signature State AUG 0 5 2009 Registrar Backs

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		For State Registrar	Otate of Wi	ai yiaii		rtificate of		ia ivierita	, ,	g. No. 2	009	21	952
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		259 Mallard Dri 5. Social Security Number		e (In vrc	last birthday)	Pasad If Under 1 Year		Hrs.   8 Dai	te of Birth				or Foreign
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is investigated by injury or other traumatic event, it is investigated by once.	ŗ	10a. State 10b. County		10c. Cit	y, Town or Lo	cation					T.	10d. Inside	City Limits
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F				11.01	(1)	10.	2	1 10			4.4			25u. Dal	Z L -	in, vay, real)	
1	(x/)	1	UW	vert	1 1luce	- MI	11	MI			0659				TIL	100	
1	6.		37. Nime and addre	ess of person wh	no completed ca	ause of de	ath (Item	23a) (Type,	Print)	. /	JESTH			2		950	
1.	21		31. Date filed (Mont	h. Dav. Year)	227	. Registrar	th (	etter	Stree	t L	JESTM	1056	-,ML	2115	) /		
	Stat Registra	e l		HE 057		)	- Jigilati	8 1									
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Registra

Richard

AUG 05 2009

31. Date filed (Month, Day, Year)

Park

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32. Registrar's Sigrature

			For State Registrar	State	of Marylan		artment of l		and Me		giene Reg. No	000	Q	21955
			Decedent's Name (First, Mid	idle, Last)					-	2. Date of Dea				. Time of Death
	Physici /Medic		Earl Leste	er Case	ev Bro	wn					04,	2009		3:20P M
	Examin		4a. Facility Name (If not institut	_			4b. City, Town,			-		County of D		
1			100 Deputed 5. Social Security Number	1 Testamo	ony Dr.		Havre If Under 1 Year		24 Hrs I	8. Date of Birt	h	arfor		e (State or Foreign
	Funeral Director		218.78.1156	1 M 2□F	50	Yrs.	Months Days		Min.	(Month, Da	y, Year) 19	58	Birthplace Country)	MD
	p		Usual Residence of Decedent					J						Inside City Limits
	arylar show	5	MD Har			ty, Town or Lo	de Grad	r.e						1 □Yes 2 No
	the M	rect	MD Har	LOLG	1.	avic	10f. Zip Code				10g. Cit	tizen of What		
	3a or	Funeral Director	100 Deputed	Testamo	ny Driv	7e	21078	3			U.	S.A.		
	death	ner	11. Marital Status		cedent Ever in U.		Was Decedent of If Yes, specify Cul	Hispanic Ori	igin? (Spec	cify Yes or No	-	14. Race - A Black, W		ndian,
36	or ite	by Fu	1 □ Nøver Married 2 M	larried 1 ☐ Yes	2 No Give		1 □Yes 2	Specify:				Specify: W		۵
Ö	hours fural	ed b	3 Widowed 4 Divorc	ed Year or lent's Education	Dates:	16a. Dece	dent's Usual Occu	pation			16b. K	ind of Busine		
215	in 72 in "na Medic	plet	(Specify only hig Elementary/Secondary (0-12	hest grade completed	(1-4or 5+)		kind of work done DO NOT use retire	during mos ed)	t of working	9	C	struc	+ 10:	·
21	ed with ygiene er tha	Completed	12			Sale	esman						LIU	
pu	be file	Be	17. Father's Name (First, Midd							(First, Middle, te Ma			er	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene.  Is marked other than "natural", or items 23a or 28a-f show raumatic event, it of Santal Examine I must be retified at	우	Robert Erne 19a. Informant's Name/Relatio			10h Maili	na Address (Stree							de) 21078
Ma			Christine A		Wife	100	Depute	d Tes	tamo	ny Dr	. H	lavre	de	Grace,MD
Ē,	is 1 al		20a. Method of Disposition		20b. F	Place of Dispo cemetery, crei	osition (Name of matory or other pla	ace)	Da			ocation - City		
<u><u>Ë</u></u>	Page ment ant: If ury or		1 ☐ Burial 2 🎉 rematio 4 ☐ Donation 5 ☐ Other	n 3 ∐ Removal from (Specify)	Che Che	esapea	ake Cre	m . :		6.09				
Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2: any Injury or other t		21. Signature of Funeral Servi	ce Licensee	M0141	43 8	2. Name and Addr 717 Gre	ess of Facilit	ъСАГА istur	A/Step es Dr	ner . E	Balto.	OHE M	ma <del>nn PA</del> D <b>212</b> 86
	402 60		23a. Part 1. Enter the disease,	or complications that	caused the deat							-	Ap	proximate
	Physician		shock, or heart failure. L Immediate Cause (Final	ist only one cause on	each line.			3,		,			Or	terval Between nset and Death
	/Medical		disease or condition resulting in death)		ophage o (or as a conseq		ancer				-		on	e year
	Examiner		Sequentially list conditions	b									_	
_	led isit	Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due t	o (or as a conseq	uence of):								
No	e be executed sician and burial-transit	Exan	that initiated events resulting in death) Last	c	o (or as a conseq	juence of):				,			-	
8760,	ate be ohysicial the buri	dical		d										
89	rtifica ng ph as th	Medi	IF FEMALE:	55582							Т			
Box 6	leath certific attending p	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 ☐ Liv	utcome of pregna	al death 3	Ectopic pregnar	ncy				23d. Date of Month	delivery Da	y Year
P.O.	that the de ned by the a detached i	ysic	1 □ Yes 2 □ No 9 □ Unknown	9 Un	gnant at time of known	ueam 51	Other (specify)							
	res that signed b be deta	by Př	Part II. Other significant cond	ditions contributing to	death but not res	sulting in the u	nderlying cause g	iven in Part I	l.	23e. Did t	obacco	use contribut	e to the o	cause of death?
ğ	w require been sig should b	ed b								1 🗆 '	Yes 2	No 3□	] Probabl	ly 4 Unknown
၁၁ခု	law ri as be	Completed								24a. Was autoj	osy	prior	to compl	findings available letion of cause of
a H	yslclan: The lavis certificate has director, page 2									1 □ Yes	rmed? 2 DVN	de <i>e</i> tl	res 2	<b>€</b> No
Zi.	siclar certif	Be c	25. Was case referred to med examiner?  1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2 □	1 EB/Outnotic	-t 20 DOA 0	hor	e of Death ursing Hom	(Check only o		€ □ Other //	216-1	
of	ding Phys h. After this funeral di	n:To	27. Manner of Death	28a. Da	te of Injury onth, Day, Year)	28b. Time of				8d. Describe		6 ☐ Other (S	specify)	
ion	Attendin death. ctor: Aft y the fun	atio	L L Mooidon	estigation			M 1[	Yes 2	No					
Division of Vital Records,	al or Att s after de al Directe ed in by t	Certification:		ermined 28e. Pla	ce of Injury - At h Iding, etc. <i>(Speci</i>	ome, farm, st ify)	reet, factory, office		2	8f. Location ( City or To			r Rural R	oute Number,
	To the Hospital or Attending PhysIclan: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical (		fying Physician: To t cal Examiner: On the and ma										
	Vithii To th	Me	29b. Signature and title of cert	tifier				nse number				ate signed (M		
9	. ^		M. Jueu	comomo			D	6020	<b>ک</b> لا		Aw	gust	05,	2009
	12		30. Name and address of pels Rosalyn Jue 31. Date filed (Month, Day, Ya	who completed ca	use of death (Ite	m 23a) (Type,	Print)	nakia	002	T_ C 02	a.	alhimm	(e n/	21231
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Registrar

State of Maryland / Department of Health and Mental Hygiene 2 🖺 🖺 🤉 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Thomas J. Beaulieu, Sr. July 28, 2009 1:06 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda nder 1 Year | If Under 24 Hrs. Suburban Hospital 8. Date of Birth (Month, Day, Year) June 24, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 ☑ M 2 🗆 F 68 1941 Michigan Director 382-40-3451 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show d other than "natural", or items 23a or 28a-f sho event, the Wedical Evantians when by notified at 1 ☐Yes 21 No Director MD Montgomery Gaithersburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20878 Funeral 901 Rockborn Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 X Married Maryland 21215-0036 1 ☐Yes 2 ☑ No Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Pages 1 and 2 should be filed within nent of Health and Mental Hygiene.
Int: If item 27 is marked other than ' Elementary/Secondary (0-12) Banker Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be item 27 is marked other traumatic ဂ Charles Boromeo Beaulieu Frances Muriel Tomkiel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 901 Rockborn Street, Gaithersburg, MD 20878 Jane Mary Beaulieu-Wife Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place)
Metropolitan
Crematory 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Aug.3,2009 | Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudoun Funeral Chapels 158 Catoctin Circle, SE, Leesburg, VA 20175 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Fournier's Gangrene disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): attending physician and for use as the burlal-tran that initiated even resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) signed by the a ☐Yes 2☐No Ö 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Retroperitoneal Hemorrhage 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed certificate 2 No 1 XYes 1 ☐ Yes of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Injury at Work? Division Hospital or Attending 24 hours after death. 1 Natural 5 Pending investigation iours after death. neral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a cal 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0061302 7-29-09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Atul Rohatgi, MD 8600 Old Georgetown Road, Bethesda, MD 31. Date filed (Month, Day, Year) Registrar's Signature State AUG 0 5 2009 Registrar

DHMH 17 Rev 1/2001

Thoma

eaulieu,

P.O. Box 68760, Division of Vital Records,

21215-0036

Maryland

altimore.

Hospital or Attending Physician: The law requires that the death certificate be execu within 24 hours after death

To the Funeral Director:
completely filled in by the f

> State Registrar

4 Homicide

(Check only one)

29b. Signature and title of certifie

M.D.

22 South Green St. Baltimore, MD 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29a. Certifier

1 🕉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

AU4176435P19681

29d. Date signed (Month, Day, Year)

AUG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Eric Douglas Bumbray 1- For State Certificate of Death Registrar 3. Time of Death 2. Date of Death Decedent's Name (First Middle, Last) Physician/ Month Day July 29, 2009 0851 hrs KKIC Douglass Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Temple Hills 4507 23rd Pkwy If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Linder 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Country) Days 06,95 Director 1X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Yes 2 No 1EMPL event, the Medical Examiner must be notified at once. Directo 10g. Citizen of What Country 10e. Street and Number 20748 450 23RS 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 2 X Married Never Married Yes Yes 2 No specify: Widowed Divorced If Yes, Give Year tment of Health and Mental Hygiene.
rtant: If item 27 is marked other than "natural",
or other traumatic event, the Medical Examiner ò 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hopartment of Health and Mental Hygiene. CULINARY CHEF 12 18.Mother's Name (First, Midgle, Maiden Surname) 17. Father's Name (First, Middle Last) DUMBRAY EDWARD DOUGLASS Be 19b. Mailing Address, (Street and Number or Ryral Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 15616 EVERGLANE LANE Dunber BROTHER ELMER 20s. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition crematory or other place) 2 Cremation 3 Removal from State X Burial 08-63-69 ESURESCTICKEN, Donation 5 Other Specify 22. Name and Address of Famility

174 REAL TUNERAL THE ature of Funeral Service Lic-WASHINGTON D.C. 20011 M01149 Approximate Interval aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Part I. Enter the disease, or complications that, Physician Between Onset and failure. List only one cause on each line. Death /Medical a. Acute heroin intoxication Immediate Cause (Final disease **xaminer** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine nause. Enter Underlying Carise (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed 23a, 27, 28a-f, perM, E g894 8/14/09 TT Physician/Medical attending physician or use as the burial -X UNPENDED Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year Live birth Fetal death Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 V Unknown þ Completed has been s 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? No certificate h Yes 2 1 V Yes 26 Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical director, Division of Vital Be Other<sub>4</sub> Hospital: 1 Nursing Home 5 Residence 6 ✔ Other: Scene DOA Inpatient 2 ER/Outpatient 3 After this 1 🗸 Yes 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a, Date of Injury Certification: 1 Natural 1 Yes 2 X No neral Director: / Pending Fd 7/29/09 Fd 8:47 am 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State 4507 23rd Pkwy Temple Hills, MD 3 6 X Could not be Suicide found at residence (Specify) To the Funeral Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifle July 30, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Victor Weedn MD JD 31. Date filed (Month, Day, Year)

State Registrar

OCME

**ORIGINAL** 

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 4959 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** August 1 2009 6:45 A E Barthelmes /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Franklin Woods Baltimore County Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 □ M 2 □ F Days 214 14 1641 87 Director September 8 1921 Baltimore Co., MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Weddaal Examiner is ust be notified at 1 ☐ Yes 2√ No Director Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4252 Necker Avenue 21236 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates: þ 1 ☐ Yes 2 🔀 No Specify: Specify: White 303 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Associate Sears 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Karl Frederick Hanf Rose Catherine Laudenklos 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) J. Henry Barthelmes 4252 Necker Avenue Nottingham, Maryland 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State August 4 2009 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. Baltimore, Maryland Signature of Funeral Service Mensee 22. Name and Address of Eacility Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disea Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final DISEASE **Physician** ATHEROSCLEROTIC HEART disease or condition resulting in death) , /Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Due to (or as a consequence of) Physician/Medical attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DIABETES - IT 1 Yes 2 No 3 Probably 4 Unknown Completed STENOSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 2 <del>4 No</del>-2 -No 1 ☐ Yes the funeral director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Norsing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 | Yes 2 | No Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division of Vital Records, P.O. Box 68760,্ Hospital or Attending Physician: 24 hours a completely within 2

Baltimore, Maryland 21215-0036

Registrar

PARSHALL 31. Date filed (Month, Day, State

29b. Signature and title of certifier

Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D40008

9105 FRANKLIN SQUARE DR. BALTIMORE, MD

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene

			1 - State of Mary		tificate of l			eg. No. 2	24960
	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death  9:10 P M
	/Medic	al	Grace Rita Bradley  4a. Facility Name (If not institution, give street and number)		4b. City. Town, or	Location of Death	August	1, 2009 4c. County of Deat	
, 2	Examin	er	4934 Lee Blvd		Shady	Side		Anne Aı	runde1
	Funeral Director			yrs. last birthday) 93 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 16,	9. Bird Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. Co. L. C	thplace (State or Foreign Luntry)  PA
	and		Usual Residence of Decedent           10a. State         10b. County         10c	c. City, Town or Loc	cation		-		10d. Inside City Limits
	Maryl I-f sho	tor	MD Anne Arundel	Shady S	Side				1 □Yes 2 XNo
	or 28g	Jirec	10e. Street and Number	,	10f. Zip Code		10	0g. Citizen of What Co	ountry?
	ath wi	Funeral Director	4934 Lee Blvd	in II S	2076		ecify Yes or No-	USA 14. Race - Ame	erican Indian.
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Eva	þ	11. Marital Status  1 Never Married 2 Married  3 Wildowed 4 Divorced  12. Was Decedent Ever Armed Forces?  1 Never Married 2 Married If Yes, Give Year or Dates:		fYes, specify Cuba	lispanic Origin? (Spi an, Mexican, Puerto Specify:		Black, Whit Specify: <b>Wi</b>	e, etc. Nite
15-0	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	durina most of worki	na I	16b. Kind of Business. <b>PG County</b>	-
12	should be filed within nd Mental Hygiene. marked other than imatic event, trains	dwo	Elementary/Secondary (0-12) College (1-4or 5+)		eteria Wo	•		District	501001
<u>م</u> 2	al Hyg other vent,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, N	Maiden Surname)	
ylar	2 should be and Mental is marked or raumatic ev	To E	Michael McAleer			Nancy			
Mar	12 sho h and 7 is m traum		19a. Informant's Name/Relationship (Type. Print)  Mary Jane Holt/ Daughter		-	and Number or Run d Shady		; City or Town, State,	Zip Code)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health Important: If item 27 i any injury or other tra <u>once.</u>		20a. Method of Disposition 2	20b. Place of Dispo	sition (Name of natory or other place		Date	20c. Location - City or	
Baltir	permit. F Departm Importar any injur		21. Signature of neral pervice Libersee		2. Name and Addre	NO		Evans Fund ie, MD 2071	
68760,	Physician /Medical Examiner  By a physician and as the priviled fransit as the priviled fransit as the priviled fransit as the priviled fransit as the priviled fransit as the priviled fransit as the priviled fransit as the priviled fransit as the priviled fransit as the priviled fransit as the priviled fransit as the priviled fransit as the priviled fransit as the priviled fransit as the priviled fransit as the priviled fransit as the priviled fransit as the priviled fransit as the priviled fransit as the priviled fransit as the priviled fransit as the priviled fransit as the priviled fransit as the priviled fransit as the priviled fransit as the priviled fransit as the priviled fransit as the priviled fransit as the priviled fransit as the priviled fransit as the priviled fransit as the priviled fransit as the priviled fransit as the priviled fransit as the priviled fransit as the priviled fransit as the priviled fransit as the priviled fransit as the priviled fransit as the priviled fransit as the priviled franciscopic franciscopic fransit as the priviled franciscopic franciscopic fransit as the priviled franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic franciscopic	cal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a co	onsequence of):	noHic (	Carch'or	las cu la	u disease	
O. Box	The law requires that the death certificat ate has been signed by the attending phy bage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 mgnths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death 3	☐ Ectopic pregnand	су		23d. Date of do Month	Day Year
ds, P.	ires that signed b		Part II. Other significant conditions contributing to death but not		nderlying cause giv	ven in Part I.			to the cause of death? Probably 4 Unknown
of Vital Records,		Completed by					24a. Was a autop: perfor 1 □Yes	sy prior to med2 death?	autopsy findings available completion of cause of s 2 \Bigsi No
/ita	Physiclan: The rthis certificate fral director, page	Be	25. Was case referred to medical examiner? Hospital:		l Ott	26. Place of Dear			
of	Physi rthis c ral dire	5	1  Yes 2  No	2 ER/Outpatier	III 3 L DOA	4 🗆 Nursing 🗔		ence 6 Other (Sp ow injury occurred	ecify)
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification: To	1  Natural 5  Pending (Month, Day, Ye investigation 3  Suicide 6  Could not be 4  Homicide determined 28e. Place of Injury building, etc. (3	- At home, farm, str	M 1 🗆	rk? ]Yes 2 □ No	28f. Location (S City or Tow	Street and Number or I n, State)	Rural Route Number,
(i		Medical C	29a. Certifier 1 Certifying Physician: To the best of m (Check only one) 2 Medical Examiner: On the basis of ex and manner stated	camination and/or in	th occurred at the to nvestigation, in my	time, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and manner date and place, and di	as stated. ue to the cause(s)
D	To the within 2 To the comple	Me	29b. Signature and title of certifier	urana		5065		29d. Date signed ( <i>Mo</i>	
			30. Name and address of person who completed cause of death $5851 - Deale$	th (Item 23a) (Type,	Print) GYK	5065.	SURA	NA MD 2	0757
	St Regist	ate rar	31. Date filed (Month Day, Year) 32. Registrar's	Signature	a del				

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09-05843 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Lea Barrier State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day July 26, 2009 Year 1458 hrs Medical Examiner LEA BARRIER

4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours Director M 2 XXF Yrs 217.17.2433 OCT 29, 1979 MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 x X No s 23a or 28a-f show c notified at once. or 28a-f shov Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic event, the Medical Examiner. MD ANNE ARUNDEI PASADENA Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 26 STONE DR 21122 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Mantal Status 12. Was Decedent Ever in U.S. Armed Forces? White, etc. 1 X Never Married 2 Married 2 XX No WHITE Divorced Yes, Give Yea Yes 2XX No specify: Specify. Widowed ğ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) HOMEMAKER 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RONALD LEE BARRIER SR. SHEILA MAE KIRBY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) RON BARRIER **BROTHER** 26 STONE DR., PASADENA , MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Bunial 2 XXCremation 3 Removal from State BAYVIEW CREMATORY INC. JULY 27, 2009 BALTIMORE , MD Other 22. Name and Address of Facility FINK FUNERAL HOME, P.A. FINK CLEN BURNIE M01148 426 CRAIN HWY S omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** ailure. List only Between Onset and each line. /Medical Death Immediate Cause (Final disease Complications of morbid obesity **xaminer** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical AMENDED 23a,27, perME, g894 8/10/09 TT X UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Day Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 🗸 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ No 3 Probably 4 ✔ Unknown 1 Yes 2 Completed has been s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? certificate h ector, page Yes 2 ✔ No Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Other<sub>4</sub> Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 1 Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: X Natural Yes 2 Pending the Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. within 24 hours after To the Funeral Direct 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b nature and title of certifier July 27, 2009 O.C.M.E. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. 62. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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		-	State of Maryland / L  State of Maryland / L  State of Maryland / L  Registrar	Department o Certificate o		rentai mygie Reg.		01000
	Physicia		1. Decedent's Name (First, Middle, Last)			2. Date of Death Month August 02	2009 Year	3. Time of Death 5:15 P M
~	/Medic	ai	Mary K. Buttner  4a. Facility Name (If not institution, give street and number)	4b. City. Town	n, or Location of Death	August 02	4c. County of Death	J.13 1 ···
	Examin	er	1511 Devere Drive	Pasader	na		Anne Arundel	-
	uneral rector		5. Social Security Number 21.7–32–7583  6. Sex 1 □ M 2 🗹 F  7. Age (In yrs. last bit) 71	irthday) If Under 1 Ye Yrs. Months Da		8. Date of Birth (Month, Day, Ye January 15,	9. Birth Cou 1938 Mary	place (State or Foreign ntry) rland
e Maryland	la-f show	ctor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Tow  Maryland Anne Arundel Pa	asadena				10d. Inside City Limits 1 ☐ Yes 2 No
th with th	23a or 28	Funeral Director	10e. Street and Number 1511 Devere Drive	10f. Zip Cod	21122		U.S.A.	
<b>5-0036</b> 72 hours after death with the Maryland	event, the Medical Examiner must be redified at	þ	11. Marital Status  1 Never Married  2 Married  1 Never Married  2 Morried  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, 2 No If Yes, Give Year or Dates:	13. Was Decedent If Yes, specify 0  1 □ Yes 2 □	of Hispanic Origin? (Sp Cuban, Mexican, Puerto No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: What	etc.
<b>5</b> 2	medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)		one during most of work etired)		b. Kind of Business/Ir	ndustry
	her th		120	Homema		e (First, Middle, Ma	Own Home	
<b>□</b> 9 7	arked ot atic ever	o Be	17. Father's Name ( <i>First, Middle, Last</i> )  John L. Kagle		Mary	Hausman	,	
aryla should b	s ⊓ark umati	P		b. Mailing Address (St.	reet and Number or Rui	al Route Number, C	City or Town, State, Z	p Code)
	tem 27 is marke				ive, Pasadena			Chata
S 1 S			4 □ Donation 5 □ Other (Specify) Cedar I	of Disposition (Name of tery, crematory or other Hill Cemetery	08-07-	-09 Bro	c. Location - City or Tooklyn Park,	
Balt permit.	Important: If any injury or once.		21. Signature of Funeral Service License	/ 3204 Mount	ddress of Facility Lyniak Funera ain Road, Pas	adena, Mary		
/M	sician ledical aminer		23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  In mediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence)	INCEI	f dying, such as cardiac			Approximate Interval Between Onset and Death
1		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	e of):				
<b>58760,</b> ficate be exect	physician and the burial-transit	edical Exa	that initiated events resulting in death) Last C. Due to (or as a consequence d.	e of):				
O. Box (	l by the attending ph tached for use as th	Physician/Medi	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ Other in the past 12 months?  9 □ Unknown  23c. If yes, outcome of pregnancy  1 □ Live birth 2 □ Fetal deal  4 □ Pregnant at time of death  9 □ Unknown			1=2	23d. Date of del Month	very Day Year
rds, P.	igned be de	by	Part II. Other significant conditions contributing to death but not resulting	g in the underlying caus	e given in Part I.	23e. Did toba 1 ☐ Yes	acco use contribute to	the cause of death?
Vital Records, sician: The law requires t	s certificate has been si lirector, page 2 should I	Completed				24a. Was an autopsy performe	nrior to o	topsy findings available completion of cause of 2 MeNo
Vita	certific rector,	Be	25. Was case referred to medical examiner?		Other:	th (Check only one,		-15.1
of Phys	After this tuneral dir	ı: To	27. Manner of Death 28a. Date of Injury 28b.	o. Time of 28c.	4 ☐ Nursing H Injury at Work?	28d. Describe how	nce 6 □ Other (Spe v injury occurred	опу)
Division of	Director: in by the	Certification: To	1 Autural 5 Pending (Month, Day, Year) 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, of	1 ☐ Yes 2 ☐ No	28f. Location (Stre City or Town,	eet and Number or Ru State)	ıral Route Number,
e Hospital	To the Funeral Director: completely filled in by the	Medical Co	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowled and manner stated.	dge, death occurred at and/or investigation, in	the time, date and place my opinion, death occu	e, and due to the ca irred at the time, da	use(s) and manner a te and place, and due	s stated. to the cause(s)
To the	To th comp	Me	29b. Signature and ittle of certifier	29c. L	icense number	3145	d. Date signed (Mont	h, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a	705,	Digit	al D	RiLI	V7141 CU
- 考	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  AUG 05 2009  22. Registrar's Signature	parke				

DHMH 17 Rev 1/2001

ORIGINAL.

# Lori Ann Cardwell 09-05861

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Department of Health and Mental Hygiene  1- For State Registrar Reg. No. 2000 2000 3
	1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month Day Year  October 1
,	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
Funeral	Honeygo Blvd & White Marsh Blvd  Perry Hall  Baltimore County  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year  If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY)  9. Birthplace (State or Foreign
Director	161-66-0745   1 M 2 X F   37   Yrs.   Months   Days   Hours   Min.   April 22,1972   PA
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits
<u> </u>	PA Delaware Media 1 Yes 2 X No
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?  274 Glen Riddle Road Apt. 201 19063 USA
ms 23a be notil	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
ter death with ", or items 23 er must be no 'Funeral	Armed Forces?    1   X   Never Married   2   Married   Armed Forces?
"natural" Examine	or Dates:  150 December 1 150 December 1 150 December 1 150 December 1 150 Kind of Business/Industry
5-0036 ed within 72 hour rlygiene. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Mental Retardation Specialist Health Care
nore, MD 21215-0036 ges I and 2 should be filed within 72 nt of Health and Mental Hygiene 1: If liem 27 is marked other than other traumatic event, the Medical To Be Complet	17. Father's Name (First, Middle, Last)  William P. Cardwell  Darlene H. Pilkington
2121 ould be fil d Mental b is marked tic event, To Be	19a. Informant's Name/Relationship (Type, Print ) (Brother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
my MD and 2 sho tealth and tem 27 is traumati	William P. Cardwell, Jr. 1413 Simpson Avenue Linwood, PA 19061  20a. Method of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
imore Pages 1 nent of H ant: If i	Burial 2 X Cremation 3 Removal from State A Donation 5 Other Specify:  Crematory or other place)  Metropolitan Crematory 7/31/09 Alexandria, VA
Baltimore, MD 21215-00.5 permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other tinjury or other traumatic event, the Med To Be Com	21. Signatur of Funeral Service Licensee  22. Name and Address of Facility  Carr Funeral Home Wallingford, PA 19086
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and
/Medical zaminer	Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injuries  Death  Due to (or as a consequence of):
	Sequentially list conditions,  b
ted ansit Examine	cause. Enter Underlying Cause (Disease or injury that initiated
and transit	events resulting in death) Last Due to (or as a consequence or):  d.
e be executed burial - transit	UNPENDED AMENDED  15 FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery
6876 ertificat iding phr ie as the	IF FEMALE:  23c. If yes, outcome of pregnancy  23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth  2 Fetal death  3 Ectopic pregnancy  Month  Day  Year
), Box 6876 the death certificate the death certificate by the attending phyched for use as the Physician/M	4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 ✓ Unknown g Unknown
Division of Vital Records, P.O. Box 6876 tallor Attending Physician: The law requires that the death certificate its after death.  "In Director: After this certificate has been signed by the attending phyled in by the funeral director, page 2 should be detached for use as the 'sertification: To Be Completed by Physician/M	1 Yes 2 No 3 Probably 4 Unknown
Records, I The law requires fircate has been sig , page 2 should be Completed	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of
Reco The law cate has page 2 s	
ftal Fisician: sician: sician: sician: sician: sician: sician:	25. Was case referred to medical examiner? [Hospital: 4 Inspital:
of Vi ing Physi After this funeral dii	27. Manner of Death  28a. Date of Injury  28b. Time of Injury  28c. Injury at Work?  28d. Describe how injury occurred  Occupant in motor vehicle collision
ision Attend r death. ector: by the f	2 Accident Investigation Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City
Division o spital or Attending nours after death. neral Director: Aft filled in by the fune Certification:	Suicide 6 Could not be determined (Specify) Major Road / Highway or Town, State) Honeygo Blvd & White Marsh Blvd, Peerry Hall , MD
the Ho hin 24 lithe Fu hyletely	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To with	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a)
	Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
State Registra	D V 0000   II   II   II   II   II   II

Darlene Helen Cardwell 09-05862

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **UNK UNK** 1- For State Certificate of Death Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day July 27, 2009 H Cardwell 0511 hrs Darlene Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Baltimore County** Honeygo Blvd & White Marsh Blvd Perry Hall Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. Date of Birth (MM/DD/YYYY) 9. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Sept 21, 1946 Director 174-36-8887 62 2X F М Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Yes 2 X No PA Delaware Media 28a-f show or items 23a or 28a-f shomust be notified at once, Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 274 Glen Riddle Rd. Apt. 201 19063 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Yes Specify: White permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Importants If item 27 is marked other than "natural", or injury or other traumatic event, the Medical Examiner. 3 XWidowed Yes 2 X No specify. If Yes, Give Year Divorced þ Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Physical Therapy Aid Health Care 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Madeline Muffley Joseph Pilkington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) Linwood, PA 19061 1413 Simpson Avenue William P. Cardwell, Jr. 20a. Method of Disposition

1 Burial 2 Cremation 3 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery crematory or other place) 7/31/09 Metropolitan Crematory Alexandria, VA Donation 5 Other Specify 22. Name and Address of Facility 935 S. Providence Rd. 21. Signature of Funeral Service Licenses 19086 Carr Funeral Home Wallingford, PA Approximate Interval nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical attending physician a for use as the burial -UNPENDED AMENDED Box 68760. 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year Live birth Fetal death Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) been signed by the att Yes 2 No 9 ✔ Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ģ Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has page 2 s death? performed? ✓ Yes 2 1 🗸 Yes No certificate 26.Place of Death (Check only one) 25. Was case referred to medica Division of Vital Be examiner? ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 this ဥ 1 V Yes No 28a. Date of Injury Jul 27, 2009 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Occupant in motor vehicle collision 1 Natural 0451 hrs Yes 2 V No 124 hours after death.

E Funeral Director; A etely filled in by the fi Pending hours after death. 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) Honeygo Blvd & White Marsh Blvd, Perry Hall, MD (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the I complet Tot and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 28, 2009 OCME 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year, 32. Registrar's Signature State arke Registra

DHMH 17 Rev 1/2001 **OCME 2006** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 🚄 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 915 Dav Year **Physician** /Medical Eacility Name (If not institution, give street and number) Location of Death 4c. County of Death Examiner ler 24 Hrs. 8. Date of Birth (Month, Day, . Age (Invrs. last birthday, If Under Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Days 1 □ M 2 F 218-12-9698 09/04/1919 Director MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show event, the Medical Examiner must be notified at Yes 2□No BALTIMORE Director MD. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö Pages 1 and 2 should be filed within 72 hours after death with 21216 2212 WALBROOK U.S.A AVENUE items 23a Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2. No Specify Specify: BLACK ģ 3 Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) TAVERN MAID 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic ovance. PARRAN MARY FRANCES FRANKLIA ္ BENJAMIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/2/5 19a. Informant's Name/Relationship (Type. Print) / DAUGHTER 5528 NOME AVE. BALTIMORE, MARVIAND NORMA EVANS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City of Town, State 20a. Method of Disposition 1 ☐ Burial 2 ACremation 3 ☐ Removal from State 05/2009 BALTIMORE, MARY LAND METRO CREMATORY INC. 4 ☐ Donation 5 ☐ Other (Specify). 22. Name and Advises of Facility THE DERRICK C. JONES FIH, PIA 21. Signature of Funeral Service PARK HGTS. 4611 Ave, BALTIMORE, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on the enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final ue to (or a) a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Phystcian: The law requires that the death certificate be executed attending physician and for use as the burlal-trar Due to (or as a conse Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown is certificate has been signed by director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 1 □ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | No 2 ER/Outpatient 3 DOA 1 Impatient Certification: To this 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 Pending investigation 1 Datural 1 ☐Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 08 npleted cause of death

State Registrar

DHMH 17 Rev 1/2001

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death James Ronald Christie **Physician** August 4, 2009 12:59A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Months Days Hours 220-40-8489 Director 66 March 19,1943 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🖾 No Directo Maryland | Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8148 Forest Glen Drive 21122 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 ☐ Never Married 2 🗙 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Plumber/AC Journeyman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Pearson Christie Syvilla Ellen Sturdevant 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Peggy Christie Wife 8148 Forest Glen Drive; Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn Mem.Garden 8/7/2009 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Sign are of preral a rvice Li e 1630 Edmondson Avenue: Catonsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** oroug /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 2 No 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☑No 2 10 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 12 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar DHMH 17 Rev 1/2001

State

4304

32 Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GARGIN

31. Date filed (Month, Day, Year)

AUG 0 5 2009

For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Las 03 2009 **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE GOOD SAMARITAN HOSPITAL BALTIMORE CITY 8. Date of Birth (Month Day, 12.27 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 77 Yrs. 6. Sex Funeral Days 1 □ M 2 💢 🖹 Director Usual Residence of Decedent 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Baltimore **Funeral Director** 10g. Citizen of What Country? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □ Yes ♀ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 😘 o land 21215-0036 Specify Completed by 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "in any injury or other traumatic event, I'm IMA ODICE. 20|lege (1-4or 5+) Elementary/Secondary (0-12) Nurse vrs. Mather's Name (First, Middle, Ma 17 Eather's Name (First, Middle, Last) Be ဥ Mary (Daughter 19b. Mailing Address (Street and Number of Baltimore, 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4☐Donation 5☐Other (Specify) 21. Signature of Funeral Service Licensee Balto. 23a. Part 1. Enter by disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. SEPTIL Immediate Cause (Final SHOCK Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): SNOOCARDITIS Examiner ORTIC VAL if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed sician and burial-trans Due to (or as a consequence of): Box 68760, physician at the burial Physician/Medical attending p IF FEMALE yes, outcome of pregnancy
□ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ CEREBROVASCULAR ACCIDENT 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy 2. No VEIN 1 □Yes or Attending Physiclan: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2√2No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this of Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Il Director: A investigation after death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a 1 — ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES 00

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

1 ☐ Yes 2 ☐ No

Year

4 Unknown

Month

1 Kayes 2 □ No

10:05 AM

31. Date filed (Month, Day, Year) State Registrar

AUG 05 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANOALEEB ABRAR \$601. Loch Raven Blvd, Buttimere, mo 21239 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-06075 State of Maryland / Department of Health and Mental Hygiene Hale Dennis Certificate of Death Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ 1211 hrs August 4, 2009 2 Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number Baltimore Maryland General Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Days Months Country) Man 600 Director 213-52-2330 2 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 1 Yes 2 Yarvlan Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number Mosher 14 Race - American Indian, Black 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married Yes Yes 2 No specify. Divorced If Yes, Give Year 3 Widowed 4 á 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Pages I and 2 should be filed within 72 hours a nent of Health and Mental Hygiene. 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+ d other than " Bethlehem Stee Steel Worker 12 Baltimore, MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Jern Be item 27 is marked (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Gough St. Baltimore Cynthia Dennis Myrick-daughter 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition crematory or other place) 2 Cremation 3 Removal from State Metro mportant: Other Specify: Donation 5 permit. Signature of Funeral Service Licenses Himore, Mans Hore proximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or Feart Physician Between Onset and failure. List only one cause on each line /Medica Atherosclerotic cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last andtran 10f per Fh, 23a,27,perME, g894 8/11/09 TT Physician/Medical X AMENDED X UNPENDED attending physician or use as the burial Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the Month Day Ectopic pregnancy Live hirth Fetal death past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 🗸 Unknown ⋧ Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? ✔ Yes 2 1 V Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other<sub>4</sub> Hospital: 1 Nursing Home 5 Residence 6 Other: DOA 2 V ER/Outpatient 3 Inpatient 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work?

Division of Vital 28a. Date of Injury (Month, Day, Year) After t 28b. Time of Injury 27. Manner of Death Certification: 1 X Natural Pending 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 3 Suicide Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD. 31. Date filed (Month, Day, Year)

Assistant Medical Examiner

29d. Date signed (Month, Day, Year) 29c. License numbe August 5, 2009 O.C.M.E. 111 Penn Street, Baltimore, MD 21201

**OCME** 

or Town, State)

28f. Location (Street and Number or Rural Route Number, City

Others State Registrar

Yes 2 No

09-06030		Please Type or Prin	nt in Black Ind	elible ir	k. Ensur	e All Co	Dies Ar	e Legibi	e.		0100
Steven Jamanarne		Eldridge State of Ma	ryland / Depart	ment of ficate of	Health an	iù Merita	rrygici	Reg. No	20	109	2496
	R	egistrar Decedent's Name (First, Middle,Last)			Dodan .		2. Date	e of Death		3. Time o	
Physician Medical Examina	-	Steven	- Eldrid		4			nth Day Just 2, 200	9 Year	1347	hrs
1		a. Facility Name (if not institution, give street a	and number)	4	b. City, Town, o	or Location of D	Death	1	4c. County of De	J/A	^
		University Hospital			Baltimore	ear If Under 2	Aldro le D	ate of Birth/Mi	W/DD/YYYY) 9.	1	tate or
Funeral		. Social Security Number 6. Sex	7. Age (In yrs. las	25	If Under 1 Ye  Months Da		1.0	ng. 30,	For	eign Country)	/ //
Director	Ľ	216-04-7071 1 M 2	F	Yrs			A	9. 30	1100		-7:
any	_	Sual Residence of Decedent  0a. State 10b. County	10c. City, T	own or Locat	ion	11.					de City Limits
<b>*</b>		Marriand NA			Bo	altimo	re				es 2 No
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vith the Maryland  23a or 28a-f show s notified at once.		702 N. Linwood A	ve.			21203	5		14. Race - Ar	nosican Indis	n Black
with ms 23	اق	1. Marita Otatas	as Decedent Ever in U.S med Forces?	13. Wa	as Decedent of I es, specify Cub	Hispanic Origir an, Mexican, F	n? ( Specify <b>`</b> Puerto Rican	es or No- etc.)	White, etc	nerican india c.	III, DIACK,
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136 Thin 73 te.	Completed	1(			Labo	•					<del></del>
21215-0036 hould be filed within 72 in Mental Hygiene. is marked other than title event, the Medical title event, the Medical	ठे	17. Father's Name (First, Middle, Last)				18. Mother's		, Middle, Maio			
2121 Suld be fill Mental Fill marked	Be	Wille Eldridge	int \	19h Mailir	ng Address (St				, City or Town, S	state, Zip Co	de) 21205
nore, MD 21215-0036 ges I and 2 should be filed within 72 hours after death with the Maryland nt of Iteath and Mental Hygiene. It: If Item 27 is marked other than "unatural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once	입	19a. Informant's Name/Relationship (Type, Pr	, ,	702		nwood		Batti	more, N	laryla:	d
ore, MD s. 1 and 2 shc f. Health and If item 27 is	1	20a. Method of Disposition		Place of Dispo	sition (Name of	cemetery,	Dat		0c. Location - Cit		
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Baltimore, permit. Pages I at Department of He- Important: If ite		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	14		Name and Addr	ress of Facility	Herker	-Fuge	of Home	PA	21229
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Box 68760, e death certificate be ex the attending physician ed for use as the burial	an/Medi	IF FEMALE: 23c. Was decedent pregnant in the	c. If yes, outcome of preg		Fetal death	3 Ectopic	c pregnancy		23d. Date of de Month	Day	Year
68 certifi nding	cian	past 12 months?	Pregnant at time of de	-	Other (Spēcify)						
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P.O. es that the igned by t	by Pl	Part II. Other significant conditions contr	ibuting to death but not r	resulting in th	e underlying cal	use given in Fa	diti.	l	2 <b>✓</b> No 3		
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Division of Vital Records, raid or Attending Physician: The law requirements and precent After this certificate has been signed in by the funeral director, page 2 should bled in by the funeral director, page 2 should b	Be (	25. Was case referred to medical examiner? Hospit	al: 1 / Inpatient 2	ER/Outpati		Other:	Nursing H		Residence 6	Other:	
f Vi Physie er this	은	1 Yes 2 No		28b. Time		. Injury at Wor			ow injury occurre	d	
n O Iding th :: Afte	io O	1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year) Aug 1, 2009	1605 hrs	1	Yes 2 ✔	No	bject shot			
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Div ital or irs aft ral Di	Certification:	4 Homicide determined	(Specify) Outside o					19 Edmonds	son Avenue, B		D
Division of Vital Records, P.O. Box 68760, within 24 hours after death within 24 hours after death. To the Funerat Director: After this certificate has been signed by the attending physician to the Funerat Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	C	(Officer city)	To the best of my knowle	edge, death of	courred at the tir	me, date and p	lace, and du occurred at th	e to the cause ne time, date a	e(s) and manner and place, and du	as stated. Je to the cau	se(s)
fa the vithin To the	Medical	and	manner stated.	and/or invest		icense numbe			29d. Date signe	d (Month, E	ay, Year)
- 310	Ž	29b. Signature and title of certifier	1	201	3	D.C.M.E.			August 4, 2	009	
		Tablics- L	Man. Ca	1946	Lus						
3		30. Name and address of person who comp Patricia Aronica-Pollak MD.	Assistant Medica	Examine	r 111 Per	nn Street, E	Baltimore,	MD 21201			
	tat		32. Registrar's Signal	ature par	Kad						
Regis			anua p.	19							

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month B **Physician** Edmon omie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 212 North Marlyn Avenue Baltimore Essex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth

Month Bay, 16931 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F Months Country) Maryland 77 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Exprired Lust be retified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Essex Maryland Baltimore Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 North Marlyn Avenue 21221 IISA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 A Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. ģ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hutzler's Dept. Store Elementary/Secondary (0-12) College (1-4or 5+) Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leon Bryant Elizabeth Wingert ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Edmond (Husband) 212 North Marlyn Avenue, Essex, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Bayview Crematory, Inc. 8/5/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Service Licensee VIn Fricker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Rd., Pasadena, Maryland 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) / /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) sician and burial-trans resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the attending physician thed for use as the burial Physician/Medical IF FEMALE signed by the attendin 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No has 24a. Was an autopsy performed? certificate 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA FResidence 6 ☐ Other (Specify) After this ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H00 6426

Registrar
DHMH 17 Rev 1/2001

State

Edmond 8/3/09 12,20pm

Baltimae 140

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

31. Date filed (Month, Day, Year)

05 2009

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Jumpy 31, P009 11:19 p.M Annette Η. Ficker /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Casey House Montgomery Rockville 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) 1 □ M 2 🛱 F Months Days Hours Min Director 17, 1939 North Carolina 212-38-3659 70 June Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Modical Exercities must be notified at Director MD Montgomery Potomac 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 10405 Garden Way 20854 Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2\times No Specify þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pediatrician Medicine injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Heiser Edith Cox ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 809 Cumberland Rd. Austin, Texas 78704 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important; If item 27 is any injury or other trau Desiree S. Ficker (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State Gate of Heaven Cem. Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Ser. Signature M00982 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Colon Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injurthat initiated events resulting in death) Last sician and burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 □ Yes 2X No 1 ☐ Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ∐ Yes 2X No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 K Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hospital or Attending Physician: The law requires that the death certificate be execute Division of Vital Records, P.O. Box 68760, after death filled in by the 24 hours a within 2 To the I

Registrar

Medical

Jocelyne Kouatchou, 31. Date filed (Month

4 Homicide

(Check only

29b. Signature and title of certifier

29a. Certifier

201 East University Parkway Baltimore, MD 21218 M.D. 32. Registrar's pignature

Koucet Chou

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

August 3, 2009

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** Joseph Ignatius Gaskins /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Hospital Cheverly If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**∑** M 2□ F Months Days Hours 79 Yrs. 577-34-2610 **Director** Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show Director DC NONE Washington 10f. Zip Code 10e. Street and Number Funeral 4315 18th St NE 20018 1 ☐ Never Married 2 ☑ Married

2. Date of Death 3. Time of Death Ye ar 80 02 2009 11:56 4b. City. Town, or Location of Death 4c. County of Death Prince George's If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 08/17/1929 DC 10d. Inside City Limits Examiner near he notified at 1 Yes 2 No 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or any Inlury or other traumatic event, Ire Medical Examine that have USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐Yes 2XINo If Yes, Give 1951-Year or Dates: 1951-Specify þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced 1953 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) years Federal Government Building Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert Gaskins Martha Fenwick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Marinda H. Gaskins/wife 4318 18th St NE Washington DC 20018 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 8/7/2009 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home 4217 9th St NW Washington DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final +XTAL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) 23c. If yes, outcome of pregnency
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Yea Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐Yes 2 ☐ No detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1X Natural 1 ☐ Yes 2 □ No 2 ☐ Accident after death Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Hospital To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and ₄itle of certifier 39. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Records, Division of Vital

Box 68760.

P.0.

DHMH 17 Rev 1/2001

State Registrar GRIFFIN

31. Date filed (Month, Day, Year)

DAVIS

3001

32. Registrar's Signature

HOSPITAL DRIVE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4, 2009 Year **Physician** AUGUST 8:00 a M JOHN GANGI /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GILCHRIST CENTER FOR HOSPICE TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Year) Days 1**X** M 2□ F Months 4,1929 MARYLAND 220-22-3489 80 MARCH Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location epartment of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show ny Irjury or other traumatic event, Ital Medical Experience must be notified at 10a. State 10b. County 1X Yes 2 No Director N/A MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3423 CLAREMONT STREET 21224 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Was Decedent Ever in U.S. Armed Forces? XYes 2 ☐ No Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 946-48 1 □ Yes 2 □ No Specify Specify: Completed by WHITE 3 ☐ Widowed 4 🎇 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) ELECTRICIAN CROWN, CORK & SEAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARGARET McGONIGLE SAMUEL GANGI ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) NANCY BUECHE/CAREGIVER 111 EASTERN STREET, GLEN BURNIE, MD. 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MOST HOLY REDEEMER 8/7/09 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility
LLY & ZEILER INC. FUNERAL HOME
0 S. CONKLING STREET, BALTO., MD. 21. Signature of Fundat Service Licensee 21224 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** year /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ursease or Figure ) that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 🗆 No Director: the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (SpecIfy) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated.

Division of Vital Records, or Attending within 24 hours after the Hospital To the Funeral

law requires that the death certificate be executed

Box 68760.

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Gangi

with the Maryland

Baltimore, Maryland 2121

and 2 should be

State Registrar

6701.N har 31. Date filed (Month, Day, Year)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

AUG 0 5 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Day 3, 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 11:40 AMM Barbara Williams Hudson 2009 August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Broadmead Health Care Center Cockeysville Baltimore 9. Birthplace (State or Foreign Country) New York If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Sep 12, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 🕱 F 82 088-28-8649 1926 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, It a Modical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Cockeysville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21030 United States 13801 York Rd. E13 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 27 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 21≾ If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Health Care Physician Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alun Williams Ada Wallace ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter Hudson / Husband 13801 York Rd. E13 Cockeysville, MD 21030 Department of Health Important: If item 27 any injury or other tr 27 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Pages 1 Aug 0.4 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit Due to (or as a consequence of); attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) signed by the a d be detached for Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was autopsy performed?/ certificate has 2 □No Vital 1 TYes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Universing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To ₹ After this Date of Injury (Month, Day, Year) 27. Manner of Death To the Hospital or Attending PI within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 W Natural 1 ☐ Yes 2 ☐ No 2 Accident ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sid

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

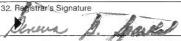
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Time of Death Month Day Year Physician /Medical 1.55 AM 2009 orraine 03 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore City** The Johns Hopkins Hospital . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** Months Hours Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County f show 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Inportant: If item 27 is marchet than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director Street and Number 10g. Citizen of What Country? 21212 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Las Be Baltimore, thed of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Cher (Specify) 21. Signature of Funeral § Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease. Immediate Cause (Final **Physician** cardiogenic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sepsis Sequentially list conditions if any cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Le to lor as a conse uence of as the burial-transit The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) attending physician Box 68760. Physician/Medical IF FEMALE: page 2 should be detached for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Division of Vital Records, P.O. 9 Unknown q Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? certificate has been signed <u>م</u> 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 2 = 2 -10 the Hospital or Attending Physician: eral Director: After this certifica filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \sum Nursing Home Hospital: 2 310 3 🗌 DOA 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 5 Residence 6 Other (Specify) ၉ Date of Injury (Month, Day Year) Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 No death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) e Funeral Direct 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 29b. Signature and title of certifie ٩ RES OOO 03, 2009

51

State Registrar 31. Date filed (Month, Day, Year) 32

and address of person who completed cause of death (Item 23a) (Type, Print)



600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** Month /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** timore 14MORE TONE If Under 1 Year | If Under 24 Hrs. Age (In y rs. last birthday) Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🗗 F Hours Franklington 246 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show ical Examiner must be notified at Baltimore 1 XYes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21211 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status filed within 72 hours after Hygiene. ☐Yes 2 No Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 þ If Yes, Give Year or Dates: Specify: Black 3 NWidowed 4 Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) House Hold Affairs Somestic Worker joyr 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filk.
Department of Health and Mental Hy
Important: If item 27 Is marked oth
any Injury or other traumattc evem Be norcon Mangum Orrina 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore MD 21218 Orinna Lee Der Laughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State Baltimore MD Aug 8, 2009 4 □ Donation 5 □ Other (Specify) pudon Park Cem: 21. Signative of Funeral Service Licensee 314 upshur St N.W. 11101182 22. Name and Address of Facility tate F/S 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 1 Medical Due to (or as a consequence of): ∉xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician and the burial-transit the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical as the attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year signed by the a 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 10 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has t page 2 autopsy perform To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, pag 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 Inatural 1 Yes 2 Accident 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 200 Zull 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HHMEN 821 n Eulaw It 32 Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 0 5 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle Last) 2. Date of Death Month **Physician** Dorethia 10:16 A M UNIVIS 09 /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner PG MID Hospital linton )outhern If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 X F Months Days Hours Min. 578 64 25 70 61 Washington Dc Director Usual Residence of Decedent the Maryland 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Completed by Funeral Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with tement of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or: ury or other traumatic event, If "Medical Exprine must be 20 (1) lemple Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Doc torate TECICHER Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 11/00re Herrold Kern ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rd lemple Temple Hills Larry Jarvis (husband 00 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages Department of I Important: If its any Injury or o once. 1 Burial 2 Cremation 3 Removal from State Cheltenham Vet Cems heltenham MD 4 ☐ Donation 5 ☐ Other (Specify) Aug 10, 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Murray Willems Funeval Home YBOY Georgia AVE N.W. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) oulmonor 4 531 M **Physician** /Medical Due to (or as a consequence of): **Examiner** Vn Sequentially list conditions, if any, leading to influented cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 07/31/04 D0064055

Registrar
DHMH 17 Rev 1/2001

State

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eric Me Dorald

31. Date filed (Month, Day, Year)

7503 Surventts

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** DORISWYN 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Nontimes Hospital Center
Security Number 6. Sex 7. Age (In yrs. last birthday RANDALISTON

If Under 1 Year If Under 24 Hrs. 8. Date BACTIMON = 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Sex 1 M 2 F **Funeral** Months Days Hours 213-52-3067 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 1 ☐ Yes 2 ☐ No MD Baltimore Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3316 USA Funeral Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 10 16 Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Maryland 21215-0036 Black 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Social Worker tyears 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Evelyn Sewell theodore Easter 19b. Mailing Address (Street and Number Rural Route Number, City or Town, State, Zip Code) Rd. Baltimore, MD 21244
Date 200. Location - City or Town, State permit. Pages 1 and 2:
Department of Health ar
Important: if Item 27 is
any Injury or other trau 20b. Place of Disposition (Name of cometery, crematory or other place) Wife Baltimore, 20a. Method of Disposition 1 Desurial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemelary 8-le-09
22. Name and Address of Facility Variabne Woodlain, Mb 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee andallstown, MD 21133 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of) Examiner DNEUMENIA Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last KLEBSIELLA URINARY TRACT INFECTION signed by the attending physician and a be detached for use as the burial-transit Due to (or as a consequence of) Completed by Physician/Medical Box ( 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 ☐ Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should b 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed this certificate MYELIES 1 Yes 20 No Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 patient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital 13 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plane, and doe to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29d. Date signed (Month. Day, Year) 29c. License number 29b. Signature and title of pertifier

State

Registrar

30. Name and address of person who complete

05 2009

DELENDO

31. Date filed (Month, Day, Year)

NORTHWEST HEAPITAL CENT

cause of death (Item 23a) (Type, Print)

GON GRAPH

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Day KATHLEEN CLARE KILHEENEY 9:30 a July 2009 31, 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death

Derwood

Montgomery

Physician /Medical **Examiner** 

19120 Muncaster Road

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "Modical Expriment is set for refilled at

Baltimore, Maryland 21215-0036

Physicia /Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

al	5	. Social Security N	Number	6. Sex		(In yrs. la	ast birthda	y) If Ui Mon	nder 1 Year ths Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	rth	9. B	irthplace (State or Forei
r	:	163-24-43	331	1□M 25	X F	80	Yrs.	IVION	uio Days	Hours	.viii I.	Sep 2,	192	8 N	ew York
	$\vdash$	Jsual Residence o													Transition in the
	1	0a. State	10b. County			10c. City	, Town or I	Location							10d. Inside City Limi
Director	1	MD	Howar	d		Colu	umbia								1 ☐ Yes 2 🔀 N
ire	1	0e. Street and Nu	mber					10f	. Zip Code				10g. Ci	Country?	
a	9	9269 Pige	eonwing	Place					21045				U.	S.A.	
To Be Completed by Funeral Director	1	Marital Status     □ Never Marr	ried 2∐ Mar	ried 1	s Decedent Ened Forces? Yes 2/12/N	ver in U.S	S. 13		ecedent of H specify Cuba	ispanic Oran, Mexicar		ecify Yes or No Rican, etc.)	D-	Black, Wh	
ed by		3 Widowed		t's Education	ar or Dates:		16a. Dec	cedent's	Usual Occup	ation			16b. K	Specify: W]  (ind of Busines)	
Completed	H		cify only highe	st grade compi			(Giv	ve kind o . DO NO	f work done o OT use retired	during mos 1)	t of worki	ng			
E O	(	Elementary/Seco Grade 12	ondary (0-12)	Con	lege (1-4or 5-	r)	C	ase	Worker	;			Me	ntal He	ealth _
Be C	1	7. Father's Name	(First, Middle,	Last)						18. Mothe	er's Name	(First, Middle	, Maider	Surname)	
년 B	į	James P.	Murray	,						Mary	/ Wat	ts			
-	-	19a. Informant's N	lame/Relations	ship (Type. Prin	nt)		19b. Ma	iling Add	ress (Street	and Numb	er or Rura	al Route Numb	er, City	or Town, State	, Zip Code)
	·	Joseph Ki	ilheene	y / s	son		926	9 Pi	qeonwi	ng Pl	Lace	Colum	bia,	Maryla	and 21045
	-2	20a. Method of Dis	sposition			20b. Pl	<u>.                                    </u>		(Name of or other place			ate		ocation - City of	
		4 Donation	5 ☐ Other (5		I from State		ensb	urg	Cathol	ic		, 2009		eensbu	rg, PA
olice olice	1	21. Signature of Fr	uneral Service	Licensee	_ / MO	0770	31					Home, Laur		Maryla	nd 20707
	T	23a, Part 1. Enter t	the disease, o	complications only one caus	that caused	the death	. Do not e	enter the	mode of dyir	ng, such as	cardiac (	or respiratory a	arrest,		Approximate Interval Between
n Y		Immediate Cause	(Final	1	Pnuemo										Onset and Death  2 weeks
		disease or condition resulting in death)		a	ue to (or as a		ence of):								
r	L					·									
ğ	li	Sequentially list co f any, leading to in cause. Enter Under Dause (Discase or	onditions, nmediate	b	ue to (or as a	consequ	ence of):								
Examin	1	cause. Enter Under Cause (Discase or that initiated events	eriying Sanjury												
	i	resulting in death)	Last	0. <u>D</u>	ue to (or as a	consequ	ience of):								
<u>ica</u>				d											
hysician/Medical		F FEMALE: 23b. Was deceder in the past 12 1 ☐ Yes 2 9 ☐ Unknown	2 months?	1 4	es, outcome of Live birth Pregnant at Unknown	2 🗌 Fetai	death 3		pic pregnanc ir (specify) _	у				23d. Date of o	delivery Day Year
<u>a</u>	F	Part II. Other signi	ificant conditi	ons contributin	g to death bu	t not resu	Iting in the	underlyi	ng cause giv	en in Part I	L	23e. Did	tobacco	use contribute	to the cause of death?
ted by		Alzheime	er's Di	sease,	Туре	Demer	ntia					10	Yes 2	- X <u>X</u> IIo 3 □	Probably 4 🗌 Unkno
Complet	-											24a. Was auto perfi 1 ∐Yes	psy ormed?	prior t death	
Be (	-2	25. Was case references	rred to medica						•	26. Place	e of Deatl	(Check only	one)		
2	ľ.	1 Yes 2 ∑	XIXO	Hospital	: 1 ☐ Inpatie	nt 2 🗆 I	ER/Outpat	ient 3	DOA Oth	er: 4□N	ursing Ho	me 5 Res	idence	6 XX ther (S	Assiste
	2	27. Manner of Dea 12. Natural 2   Accident	5 Pendii		Date of Injur (Month, Day		28b. Time Injury		28c. Injur Wor 1 🗆			28d. Describe	how inju	ry occurred	Living
Sertification:		3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could detern		Place of Inju			street, fa	ctory, office			28f. Location City or To			Rural Route Number,
edical C		29a. Certifier (Check only one) (	2 Medical	ng Physician: Examiner: Or e Praed	n the basis of	examinat									as stated. lue to the cause(s)
₹	1	29b. Signature and	d title of certifie		٦				29c. Licens	e number	-		29d. Da	ate signed (Mo	onth, Day, Year)
		1	llen	150	all	lle	OR.	M	Re	2860	63	7	Au	gust	1,200
	3	80. Name and add	lress of person	who complete	d cause of de		23a) (Typ	e, Print) Sf	arte	ny (	rate	4 W	rall	ine n	nd 2179

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 253 **Physician** 2009 J0SEPH SCHIFFER KAUFMAN /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ba HOSPITAL SINAL timore NIA Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05-08-1930 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1**∑** M 2□ F 212-28-5226 MD **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location the Marylan 23a or 28a-f show event, the Medical Examiner must be notified at 1 X Yes 2 □ No MD Director BALTIMORE N/A 10f, Zip Code 10g. Citizen of What Country? 10e Street and Number USA 21209 Funeral 2202 KEN OAK ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items, 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No Specify: ģ 3 Widowed 4 Divorced WHITE "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If fem 27 is marked other the any Injury or other traumatic event, Ital once. ATTORNEY LAW 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KAUFMAN ROSE SCHIFFER 2 HARRY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SHIRLEY KAUFMAN/WIFE 2202 KEN OAK ROAD, BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW 08-04-2009 REISTERSTOWN, MD 21. Signature of uneral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) tente Cerebra Physician days /Medical Due to (or as a consequence of): Examiner fibrillation rial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed ardiomyopat sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ੬ heart failure 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death Director: A 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

i 24 hours **af** e Funeral D letely filled in within 24 ho
To the Fune
completely f

> State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only one)

Laura

10755 Falls Road Lutherville, MD M Muntord MD 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

D 0018410

29d. Date signed (Mgnth, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- For State Registrar Certificate of Death Reg. No. 2009 24
/led	Physicia lical Exami	an/	1. Decedent's Name (First, Middle,Last)  2. Date of Death  MADTTN DDTAN VICTOV  And DTTN DDTAN VICTOV  3. Time of Death  Month Day Year  2. 2.17 bro
			4a. Facility Name (if not institution, give street and number)  Harbor Hospital Center  4b. City, Town, or Location of Death  V/A
	Funeral Director		5. Social Security Number 213-27-9408 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Months Days Hours Min. Dec 20, 1976 Foreign Country) Mary Land
	w any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limi Paryland Anne Arundel Baltimore 1 Yes 2 X 1
9	death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	
10	th with the lems 23a or it be notifu	Funeral Di	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
	more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ent of Health and Manhall Hygens, and the Health and Manhall Hygens, and the History or items 23a or 28a-f she in til filems 77 is marked other than "natural", or items 23a or 28a-f she in other traumatic event, the Medical Examiner must be notified at once	by	3 Widowed 4 Divorced of Yes, Give Year or Dates 1 Yes 2 X No specify: Specify: Specify: White
	)36 thin 72 hou ne. than "nat edical Exa	Completed	Elementary/Secondary (0-12)  12  College (1-4 or 5+)  4  during most of working life. DO NOT use retired)  Professional Wrestler  UFC
	Jre, MD 21215-0036 st and 2 should be filed within 72 of Health and Mental Hygiene. If item 27 is marked other than 'her traumatie event, the Medical	Be Con	Michael David Kusick Donna Lee Broseker
	e, MD 2121: I and 2 should be fill Health and Mental I item 27 is marked	T <sub>O</sub>	19a. Informant's Name/Relationship (Type, Print)  Michael David Kusick (Father)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  6067 Wallops Mill Drive, PO Box 94, Horntown, Va. 23395
	Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		1 X Burial 2 Cremation 3 Removal from State Crematory or other place)  Cedar Hill Cemetery  8/10/09  Baltimore, Maryland
	Baltin permit. Departm Importa		21. Signature Funeral Service Licensee Kevin E Ecker  22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A.  237 E. Patapsco Ave., Baltimore, Md. 21225-1856
	Physician Medical caminer	9 79	23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Inter Between Onset a Death  Immediate Cause (Final disease a. Cocaine intoxication
(	yammer		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.
		Examiner	
	xecuted n and l - transit	cal Ex	
	8760, rificate be executed g physician and s the burial - transit	n/Medical	1925 Man decodest proposit in the North Pay Voor
	Box 68 death cert he attendir d for use a	Physician	past 12 months?  4 Pregnant at time of death 5 Other (Specify)
	P.O. res that the signed by t	d by Pl	1 Yes 2 No 3 Probably 4 V Unknow
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition.	Completed	24a. Was an autopsy prior to completion of cause performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
	tal Rician: T	BeC	25. Was case referred to medical 20. Place of Death (Check only one)
	of Vi ng Physi After this meral dii	12	1 ✓ Yes 2 No  28 Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
	Sion Attendin death.	catio	Natural 5 Pending Investigation Accident 7/30/09 Fd 10:30 pm 1 Yes 2 X No unk  Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural Route Number, or Rural
	Divi	Certification:	3 Suicide 6 X Could not be determined (Specify) Parking 1ot 1288. Place of Injury - At nome, farm, street, factory, office building, etc. or Town, State) 200 14th Ave.  8 Suicide 4 Homicide 1288. Place of Injury - At nome, farm, street, factory, office building, etc. or Town, State) 200 14th Ave.  8 Brooklyn Park, MD
	Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	
	To vii	Me	
			30. Name and address of person who completed cause of death (Item 23a)
			Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
	5	State strai	a 31. Date filed (Month, Day Year) B2. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	aryland	-	artment of H			ental Hy	giene Reg. No.	009	24982
f	Physici	an	1. Decedent's Name (First, Middle, La	,						2. Date of De Month	Day	Year	3. Time of Death
	/Medic	cal	W7 LLIAM L 4a. Facility Name (If not institution, give	USTICA re street and number)			4b. City, Town, or	Location		JULY	31 4c. Co	2009 ounty of Death	
	E X a IIIII	ler		AL CENT	ER			1 MC	ORE			N/A	
	Funeral Director		212-42-0830	Sex 7. Age	e (In yrs. Ia 65	ast birthday) Yrs.	If Under 1 Year Months Days	If Unde Hours	er 24 Hrs. Min.	8. Date of Bir (Month, Da Nov. 3,	th ay Year) 1943	9. Birth Cou Mar	place (State or Foreign intry) y Land
	yland		Usual Residence of Decedent  10a. State  10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
	a-fsh	ctor	Maryland Anne Ar	undel	Pasao	dena							1 □Yes 2 XNo
	be filed within 72 hours after death with the Maryland that Hygiene. d other than "natural", or items 23a or 28a-f show event, he Medical Evan har matter and be notified at	Funeral Director	10e. Street and Number 1202 Oakharbor Court				10f. Zip Code 21122				-	n of What Cou.S.A.	intry?
	ms 23	neral	11. Marital Status	12. Was Decedent B	Ever in U.S	3. 13. V	Was Decedent of Hi f Yes, specity Cuba	ispanic C	rigin? (Spe	cify Yes or No		Race - Amer	ican Indian,
92	after o		1 Never Married 2 Married	Armed Forces?  1  Yes 2 4	No		fYes, specity Cuba I∐Yes 2∰No	in, Mexica Specif		Rican, etc.)		Black, White,	
	hours tural",	ed by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			dent's Usual Occup					of Business/I	ite
215	nin 72 s. In "na'	plet	15. Decedent's E (Specify only highest gra		4)	(Give life. L	kind of work done of DO NOT use retired	during mo	ost of workin	g			
21	ed with	Completed	Elementary/Secondary (0-12)	College (1-4or 5	*/	St	tevadore					ship Tra	de
Baltimore, Maryland 21215-0036	be de de	To Be	17. Father's Name (First, Middle, Last Frank	)		Lustica	a	Soph:		(First, Middle	, Maiden Su	rname)	Fleyzor
ary	s 1 and 2 should be if Health and Mental item 27 is marked o other traumatic ev	-	19a. Informant's Name/Relationship				g Address (Street a						ip Code)
ອົ ໜົ	1 and 2 Health em 27 i		Pauline A. Lustica (W	ife)	Tank Bu		Oakharbor C						
nor L	0 0		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐				sition (Name of natory or other place Cenetery	e)	08/04/	ate '00		tion - City or T vn Park	Maryland
att	permit. Pag Department Important: I any Injury o	3	4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lices		I INI			s of Faci				· ·	TER YERRI
ñ	B II D B		1-10	p-		3	Name and Address Cully—Poly 204 Mountai	n Roa	d Pasac	lena, Ma	ryland 2	21122	
		0 ×	23a. Part 1. Enter the disease, or comshock, or heart failure. List only	one cause on each lir	10.			G6565'			rrest,		Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)				tory f	AIL	URE				
H.	Examiner		f	Due to (or as		200	LREST						5 minuty
	ed sit	iner	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury	Due to (or as		ence of j.							5 minet
	be executed ician and burial-transit	Examine	that initiated events resulting in death) Last	c. HEPA Due to (or as	a conseque	ence of):	SCEPHAL	-071	4747	<u>'</u>			1501
9/60	icate be executed physician and the burial-transit	dical E		⊾d									Loay
R S X	death certificate e attending physi d for use as the b	Med	IF FEMALE:	00 1/									
ROX	attenc for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 🗆 Fetal	death 3□	Ectopic pregnancy Other (specify)	4			230	d. Date of deli Month	very Day Year
	t the d by the ached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	tuno or de	, au							
<u>'S</u>	iician: The law requires that the death certific certificate has been signed by the attending t rector, page 2 should be detached for use as	by P	Part II. Other significant conditions	ontributing to death bu	ıt not resul	ting in the ur	nderlying cause give	en in Part	t I.				the cause of death?
	requir	eted								10	$\overline{}$		
ě	The faw ate has b page 2 st	Completed					<del></del>				psy ormed?	prior to o death?	opsy findings available ompletion of cause of
_	lan: Trifficat	BeC	25. Was case referred to medical					26. Plac	ce of Death	1 ☐ Yes	2 A No	1 □ Yes	2 No
> TO	Physician: this certific ral director,		examiner? 1 ☐ Yes 2 DVNo	Hospital: 1 Inpatie	nt 2 🗆 E	R/Outpatien			Nursing Hon	ne 5□Res	dence 6	Other (Spec	ify)
	ding P h. After funera	Certification: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injui (Month, Day		28b. Time of Injury	Work	yat ⊲? Yes 2.[		8d. Describe	how injury o	ccurred	
DIVISION	Atten r death sctor: by the	ificat	3 Suicide 6 Could not b	e 28e. Place of Inju	iry - At hor	ņe, farm, stre		ies ZL				lumber or Ru	ral Route Number,
5	rtal or rs afte al Dir	Cert	4 ☐ Homicide determined	building, etc	с. (Ѕреспу,	,				City or To	wn, State)		
	to the hospital or Attending Physician: thin 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier 1X Certifying PI  (Check only 2 Medical Examone)	nysiclan: To the best of niner: On the basis of and manner sta	examinati	vledge, death ion and/or inv	n occurred at the tin vestigation, in my o	ne, date a pinion, de	and place, a eath occurre	and due to the ed at the time	cause(s) ar date and pla	nd manner as ace, and due	stated. to the cause(s)
	vithin To the	Me	29b. Signature and title of certifier	1			29c. License	e number				signed (Month	
			Horeen Ads	ak Mo	<b>&gt;</b>		R	Es i	100		July	131,	2009
			30. Name and address of person who HANEEN ATBAK	completed cause of de	eath (Item	23a) (Type, I	Print) 8 TREET	. 2.	ALTIN	WRF	MD :	2122	5
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signatu	ure	STREET	. "D"	10 (1)	-U, L			_
	Registr	ar	AUG 05 2009	Denesa	1.	Back							

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		ame <i>(First, Middle</i> : <b>ffrey</b>	Steven	Miller				2. Date of D Month	Day	2009	3. Time of Death 12:52p
dical niner		e (If not institution	n, give street and	number)		4b. City, Town	, or Location of De	July eath		County of Death	
		House				Westmi				arroll	
al or	5. Social Securit  220-52-	4838	6. Sex 1 <b>X</b> M 2□ F	7. Age (In yrs.	. last birthday) Yrs.	If Under 1 Yea Months Day		in. 8. Date of E (Month, I 03/06/	Birth Day, Year) 1949	9. Birth Cou	nplace (State or Fore untry) MD
o.	Usual Residence 10a. State MD	10b. County	timore	10c. Ci	ity, Town or Lo	cation 11dwin					10d. Inside City Lim
Director	10e. Street and	Number <b>Ansari</b> L	ano			10f. Zip Code <b>210</b>			10g. Citia	zen of What Cou	untry?
by Funeral	11. Marital Statu 1 X Never M 3 Widowe		12. Was De Armed 1 □ Ye If Yes,	ecedent Ever in U Forces? s 2 <b>X</b> No Give r Dates:			of Hispanic Origin? uban, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)		14. Race - Amer Black, White Specify: <b>Wh</b>	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** of AM 03 Milton McCoy Sr. David 08 1003 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital Baltimore Year If Under 24 Hrs Days Hours Min. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months Days Yrs 92 Director 15 217-09-4287 Usual Residence of Decedent 01 17 VA with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Modical Examination at the notified of 1 Yes 2 No Reisterstown Director Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21136 U.S.A. 15 Folly Farm Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No Specify. 2 Specify: 3 Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within in one of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Trucker Trucking Company 8th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked ပ္ Jessie Beverly John McCov 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any Injury or other trau 15 Folly Farm Court, Reisterstown, Md 21136 Diane Person-Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Y□ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Arbutus Memorial Park 8/10/09 Arbutus, Md 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
March F/H West Takan 4300 Wabash Ave, Baltimore, Md 21215 Part 1. Ent is the disc. Se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY Physician /Medical Due to (or as a consequence of): Examiner AMIODARONG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ASPIRATION BRONCHITI attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> CONGESTIVE NEART FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed CHRONIC RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has page 2 s performed? certificate h 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To funeral 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar

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29b. Signature and title of certifier

JEAN CLAUDE

31. Date filed (Month, Day, Year)

AUG 05 2009

Jarka

29c. License number

RES 000

5601 LOCH RAVEN BLVO, BALTIMORE, MD

29d. Date signed (Month, Day, Year)

08-04-2005

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BASSILA

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State of Maryl State of Maryl Registrar	land / Department of He Certificate of D		ntal Hygiene	nne i 4 5
Physic		1. Decodent's Name (First, Middle, Last)	•	2	Date of Death	Year 3. Time of Death
/Med Exam		4a. Facility Name (If not Institution, give street and number)	46 City, Town, or L Baltin	ocation of Death	4c. Co.	unty of Death
Funera Directo		5. Social Security Number 6. Sex 7. Age (In 17-50 - 4912 Usual Residence of Decedent	yrs. last birthday) If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
-0036 hours after death with the Maryland tural", or items 23a or 28a-f show al Evanniar must be notified at	tor	10a. State 10b. County 10c	301 timore			10d. Inside City Limits 1 ☐ es 2 ☐ No
with the 3a or 28a	I Director	10e. Street and Number 1772 E. North Aven	10f. Zip Code	12	10g. Citizen	of What Country?
fter death r items 2	Funeral	11. Marital Status  12. Was Decedent Ever in Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 ■ No	If Yes, specify Cuban,	, Mexican, Puerto Ri		Race - American Indian, Black, White, etc.
215-0036 thin 72 hours aff ne. an "natural", or	ted by	Widowed 4 □ Divorced Year or Dates:	16a. Decedent's Usual Occupati	Specify:		of Business/Industry
Z was a	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give kind of work done due life. DO NOT use retired)  Administration		start Hec	14 Care
aryland should be file and Mental Hy smarked othe	To Be (	17. Father's Name (First, Middle, Last)  James Holley Se	1	18. Mother's Name (1	First, Middle, Maiden Sur. 2 <b>H Steve</b>	name)
and 2 sho ealth and m 27 is mentrauman		19a. Informant's Name/Relationship (Type Potrughter) Helena N. Thomas	19b. Mailing Address (Street and Street and		Route Number, City or To	wn, State, Zip Code)  MD 21200
timore, t. Pages 1 al tment of Hez tant: If item			Ob. Place of Disposition (Name of cemetery, crematory or other place)	Dat		on - City or Town, State
Balti permit. Departm Importa any inju		21. Signature of Funeral Service Licensee	Vaugh	K. Vd.		al Services
Physician		23a. Part 1. Enter the disease, or complications that caused the c shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	leath. Do not enter the mode or dying,	, such as cardiac or r		Approximate Interval Between Onset and Death
/Medical Examiner		disease or condition resulting in death)  a. (**)  Ce to lor as a condition a. (**)	(A) Insequence of):	/		18 insums
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	isequence of):			
18760, cate be executed physician and the burial-transit	dical Exa	that initiated events ' c Due to (or as a con	sequence of):			
BOX 687( eath certificate attending physical for use as the b	n/Medi	IF FEMALE: 23c. If yes, outcome of pre 23b. Was decedent pregnant			23d.	Date of delivery
the death by the atte	Physician/Me	in the past 1¼ nonths?  1 ☐ Yes 2 No 9 ☐ Unknown				Month Day Year
Cords, P.O. Box 6 w requires that the death certifi theen signed by the attending is should be detached for use as	þ	Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given	in Part I.	23e. Did tobacco use o	contribute to the cause of death?
He lan	Completed	5			autopsy performed?	4b. Were autopsy findings available prior to completion of cause of death?
	Be C	25. Was case referred to medical examiner?		26. Place of Death (	1 □ Yes 2 ZNo Check only one)	1 ☐ Yes 2 ☐ No
Of O	7: To	27. Manner of Death 28a. Date of Injury	2 ER/Outpatient 3 DOA Other:	at 28	5 Residence 6	Other (Specify) WOSPIU curred
DIVISION OF all or Attending Phy after death. Offector: After this d in by the funeral d	catio	i San Natural 5 ☐ Pending (Month, Day, Year 2 ☐ Accident investigation 3 ☐ Sulcide 6 ☐ Could not be	M 1 □Ye	es 2 🗆 No		
DIVISION OF VITA  To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification: To	4 ☐ Homicide determined 28e. Place of Injury - A building, etc. (Sp.	At home, farm, street, factory, office pecify)		City or Town, State)	umber or Rural Route Number,
e Hosp 124 hou e Fune iletely fi	ledical	29a. Certifier (Check only one)  Certifying Physician: To the best of my and manner stated.	knowledge, death occurred at the time mination and/or investigation, in my opin	e, date and place, an nion, death occurred	d due to the cause(s) and at the time, date and pla	d manner as stated. ce, and due to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier	29c. License r	number -	29d. Date si	gned (Month, Day, Year)
6		30. Name and address of person who completed cause of death (	(Item 23a) (Type, Print)	0503	Mysos	7 2009
9 √	o ke	31. Dale filed (Month, Day, Year) - 32 Registrar's S	W G70(N)	Charles	ST D	wow mp
St Regist	ate	MIC 05 2000	A barles			

09-06022 Mar

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Mary	McNally		1- For State	tate of Maryland		artment of <i>rtificate of</i>		and I	Mental	Hygiene	Reg. No	201	9 2 9 5
Mad	Physicia Iical Exami		1. Decedent's Name (First, Mid	dle,Last) res McNally						2. Date of D Month	eath Day	Year	3. Time of Death 0955 hrs
Med	IICAI EXAIIII	ilei	4a. Facility Name (if not institut			4	b. City, Town	n, or Loc	cation of D	August :		9 4c. County of Death	
			3817 East Northern				Baltimore					Baltimor	•
	Funeral Director		5. Social Security Number 210 24 6200		e (In yrs. Ia 6	ast birthday) Yrs.	If Under 1	Year Days	If Under 2	Min. Novemb		M/DD/YYYY) 9. Bir 1932 Foreig Co	
	any		Usual Residence of Decedent  10a. State 10b. County	/	10c. City,	Town or Location	on						10d. Inside City Limits
ā.	and show: nce	'n	Maryland Balti	more City	Balti	more							1 X Yes 2 No
14685	the Maryl t or 28a-fiffed at	10e. Street and Number 10f. Zip Code 21206							itizen of What Cou	ntry?			
4	Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23n or 28n-f show any injury or other traumatic event, the Medical Examiner must be notified at mee	uneral	11. Marital Status 1 Never Married 2	12. Was Decedent Armed Forces						? (Specify Yes or uerto Rican, etc.)	No-	14. Race - Amer White, etc.	ican Indian, Błack,
	safter d ral", or niner m	by Fu		ivorced If Yes, Give Year or Dates:			Yes 2XX				lan	Specify: White	
	72 hour n "natu al Exan	Completed	15. Decedent's Education (Sp Elementary/Secondary (0-12	) College (1-4 or			ost of working	life. D				. Kind of Business/	Industry
	0036 within giene. her than	ompl	12 17. Father's Name (First, Middl	N/A		Business	s Manage		Mothos's N	lame (First, Middl		ospital	
	215- be filed ntal Hyg rked off	Be C	Caruella Centol	oene					Mary	Theresa Za	ccarc	)	
	MD 21215-0036 td 2 should be filed within 7 tlth and Mental Hygiene. no 27 is marked other than aumatic event, the Medica	T <sub>0</sub>	19a. Informant's Name/Relation  John Kovac	nship (Type, Print )			Address (S			r or Rural Route N est Hill, I		City or Town, State	e, Zip Code)
	Te, N Hand S Health Citem		20a. Method of Disposition	on 3 Removal from St		Place of Disposi crematory or oth	tion (Name o			Date		c. Location - City or	Town, State
	Baltimore, permit. Pages I ar Department of Her Important: If ite		4 Donation 5 Other	Specify:	are	iro Cremat	ory Inc			4 2009	Ba	altimore,Ma	ryland
	Bal permit Depar Impo	7	24. Signature of Funeral Service	1/8	$\bigcirc$	La	ame and Add ASSAHN F 101_Bela	unea	al Home	e Inc altimore_M	arvla	and 21236	
	Physician /Medical	failure. List only one cause on each line. Multiple drugs (trazodone, citalopram, and Between									Approximate Interval Between Onset and Death		
	xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Lorazepam) intoxication  Due to (or as a consequence of):										
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus	b. Due to (or as a cons	equence o	of):							
1.1	<b>1</b>	Examiner	(Disease or injury that initiated events resulting in death) Last	C	equence o	of):	-		-				
M	c 68760, C. octificate be executed ending physician and use as the burial - transit	lical E	<b>X</b> UNPENDED	d. AMENDED 23	a,27	,28a-f, <sub>1</sub>	erME,	g8	94 87	13/09 TI	1		
		sician/Medical	IF FEMALE: 23b. Was decedent pregnant in	23c. If yes, outcome the Live birth	me of preg		al dooth	3	Ectopic pr	reanancy	12	23d. Date of deliver	y Day Year
	Division of Vital Records, P.O. Box 6876 tal or Attending Physician: The law requires that the death certificat rs after death.  "I Director: After this certificate has been signed by the attending phied in by the funeral director, page 2 should be detached for use as the	/sicial	past 12 months?  1 Yes 2 No 9 ✓ U	4 Pregnant a	time of de	ooth	al death ner (Specify)		Lotopic pi	egnancy		WO.IIII	Day Tour
	hat the ded by the letached	by Phy	Part II. Other significant cond		h but not r	esulting in the u	nderlying cau	use give	en in Part I				the cause of death?
	ds, P equires t een sign ould be o									24a. W		24b. Were a	bably 4  Unknown  utopsy findings available
	tal Records cian: The law requi certificate has been ector, page 2 should	ompleted	-								itopsy erformed es 2		completion of cause of es 2 No
	n of Vital Recc ling Physician: The lav After this certificate ha funeral director, page 2	Be C	25. Was case referred to medic examiner?	Hospital:					her:	neck only one)			
	n of Vil ing Physic After this funeral dire	To	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	ent 2	ER/Outpatient 28b. Time of Ir			her4 N	lursing Home 5 28d. Descri		idence 6 🗸 Othe	er: Scene
	ion (tending eath. the fun	ation		nding (Month, Day, Fd 8/2/	_	Fd 9:15	o am	Yes	2 <b>X</b> N	subjec	t i	ngested d	rugs
	Division lal or Attend rs after death al Director: led in by the	Certification:	3 X Suicide 6 Co	28e. Place of Ir	njury - At h	ome, farm, stree	t, factory, off	ice buil	ding, etc.	28f. Location or Tow	n (Stree	et and Number or R ) 3817 E. ltimore,	ural Route Number, City Northern
	Division of Vital Records, P.O. Box To the Bospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for a	Medical Co	4 Homicide  29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of mainter:On the basis of exa	ny knowled imination a	lge, death occun	red at the tim	e, date	and place	, and due to the c	ause(s)	and manner as sta	ted.
	To To	Mec	29b. Signature and title of certi	and manner stated.			29c. Lie					d. Date signed (Mo	
			my mi,	N.S			0	.C.M.	E.		Α	ugust 3, 2009	
	0		30. Name and address of personal Ling Li, MD Assistant	on who completed cause of cant Medical Examine	,	n 23a) Penn Stree	t, Baltimo	re, M	D 21201	1			
		tate	31. Date filed (Nonth, Day Yea	<u> </u>									
	Regis	tror	MALICE U.S. ZWWY	wind /	4. 19	The same of the same of							

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ State	State of Maryland	Department of F  Certificate of I			2000	01.007
			Registrar  1. Decedent's Name (First, Middle, Last)		Certificate of I	Dealii	Reg. N	10. 2003	3. Time of Death
	Physici /Media		OLGA	MATISZ	IW			7 2 109	7.3/ AM.
	Examir		4a. Facility Name (If not institution, give s	11.	PASA	r Location of Death	110	1c. County of Death	RUNDEL CO
	Funeral Director		170.66.6109	7. Age (In yrs. last	birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea MARCH 7, 1	ar) Cour	place (State or Foreign ntry) RATNE
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Location			1	0d. Inside City Limits
	Maryl -f sho	ţo	MD ANNE ARUND	FI PASA	.DENA				1 □Yes 2XXNo
	h the	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cour	ntry?
	23a c		8668 NORWALK HARBOUR			21122		USA	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it and the Exercity of the Exercity of the police. Once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒️XVidowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 _Yes _2\foxtilde{X} No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 □Yes 2 ☑\No	dispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: WH	
21215-0036	nin 72 hou e. t <b>n "natur</b> M. <b>IIcall</b>	Completed	15. Decedent's Educ (Specify only highest grade		6a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	during most of workir		Kind of Business/In	dustry
21	er tha	E O	6	College (1 101 C1)	HOUSEKEEPER			MESTIC CLEA!	41NG
Maryland	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)				(First, Middle, Maid	len Surname)	
yla	should be ind Mental marked o	မ	GREGORY SOVA	7.00	19b. Mailing Address (Street	MARIA SAVO		huar Taum Stata Zie	- Codo)
⊠ ⊠	d2sh Ithan 17 isr traur		19a. Informant's Name/Relationship (Typ	,	8668 NORWALK HAR				Codey
ē,	s 1 and 2 s of Health a item 27 is other trau	1	MARY MATISZIW  20a. Method of Disposition	20b. Plac	e of Disposition (Name of etery, crematory or other place	D		Location - City or To	own, State
	Pages nent of I ant: If ite ury or of		1XXBurial 2 ☐ Cremation 3XXRe 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	ADIMIR'S RUS. OR	i	/8/2009 JAC	KSON TOWNSH	IP, NJ
Baltimore,	permit, Pages Department or Important: If i any injury or once.		21. Signature of Fuperal Service License	D. MO145.	22. Name and Addre FINK FUNERAL 426 CRAIN His	HOME, P.A.	BURNIE . MD	21061	
	Physician /Medical Examiner	ər	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	pations that caused the death. It is cause on each line.  Due to (or, is a consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequent of the consequen	IVE HEITA	ng, such as cardiac c		E PEE	Approximate Interval Between Onset and Death
	ficate be executed physician and s the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen	nce of):				
P.O. Box (	The law requires that the death certifiate has been signed by the attending age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deal 9 ☐ Unknown	eath 3 Ectopic pregnance	су		23d. Date of deliv Month	very Day Year
σ.	res that signed b be deta	by Pt	Part II. Other significant conditions con	0		ven in Part I.	23e. Did tobacc	co use contribute to t	he cause of death?
ğ	w require s been się should b		MITRAL	- KEGURGI71	77,00		1 ☐ Yes	2XNo 3□ Pro	bably 4 Unknown
Division of Vital Records,	<b>ding Physician:</b> The law ro h. After this certificate has be funeral director, page 2 sh	Completed	0188878	S MELLITA	s type I		24a. Was an autopsy performed 1 □ Yes 2	prior to co	opsy findings available ompletion of cause of 2 □ No
Vita	ician: certific ector,	Be	25. Was case referred to medical examiner?	ospital:	Oth	26. Place of Death	(Check only one)		
o	Phys rrthis aral dii	: To	1 ☐ Yes 2 🛣 No	28a. Date of Injury 28	Bb. Time of 28c. Inju	rv at	me 5 Residence 28d. Describe how it	e 6 ☐ Other (Speci njury occurred	<i>fy</i> )
rision	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director, it	Certification:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident 1 ☐ Could not be 4 ☐ Useriale determined	(Month, Day, Year)  28e. Place of Injury - At home	Injury Wor	rk? ]Yes 2 □ No		t and Number or Run	al Route Number,
á	pital or ours afte eral Dire		4   Hornicide	building, etc. (Specify)	adde death anoured at the t	imo, dato and place	City or Town, Si		etated
1	To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu	Medical	29a. Certifier (Check only one)  Certifying Phys 2 Medical Examir	ician: To the best of my knowle ner: On the basis of examination and manner stated.	n and/or investigation, in my	opinion, death occur	red at the time, date	and place, and due t	to the cause(s)
J	Vith Voith	Σ	29b. Signature and title of certifier	1 - las	29c. Licens	se number	Z 29d.	Date signed (Month,	Day, Year)
			20 Name and address of parson the as	mpleted cause of death (Item 2:	3a) (Type Print)	011/0		00/04	2001
-			30. Name and address of person who co			حلال ال	d Relst	el Paso	demm
			31. Date filed (Month, Day, Year)	32. Registrar's Signature	e				2 2 >

Registrar

AUG 05 2009 Down S. faces

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental	Hygiene
Certificate of Death	Reg. No. o o

		-	For State Registrar	State of Mai	,	epartmer Certificat			-	Reg. No. O	00 210	0.0
	Physicia		Decedent's Name (First, Middle, Le  Raymond	Augustine	) Mo	Carthy,	Tr		2. Date of Dea Month AUGUS	Day	Year 21:56	
	/Medic		4a. Facility Name (If not institution, gi Saint Joseph	ve street and number)		4b. City,		ocation of Deat	h	4c. County		
	Funeral Director		5. Social Security Number 6. 212–26–7039		(In yrs. last birth			f Under 24 Hrs. Hours Min.		th y, Year)	9. Birthplace (State or Fo	oreign
yland	how		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location					10d. Inside City L	
he Mar	28a-f sl	Director	Maryland Baltin	ore	Ba	1timore	Code			10g. Citizen of W	1 Tyes 2	XX°
h with t	23a or 3	al Dir	10e. Street and Number 2410 Woodcroft H	Road		101. 21		234			U.S.A.	
Q Z IZI3-UU30 filed within 72 hours after death with the Maryland	if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Francisca must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2XXMarried 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 Wes 2 No If Yes, Give 1 9 Year or Dates:		13. Was Dece If Yes, spe 1 □ Yes		panic Origin? (S Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	- 14. Race Blac Specify	e - American Indian, k, White, etc. White	
<b>3-0-</b>	natura dical F	eted	15. Decedent's E (Specify only highest g	ducation	16a.	 Decedent's Usu <i>(Give kind of w</i> o	rk done dur		rking	16b. Kind of Bu	usiness/Industry	
within	jene. r than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	)	Steel Wo				Bethlehe	em Steel	
	ed other	Be	17. Father's Name (First, Middle, Las		·				me (First, Middle,	Maiden Surnam Fealy	e)	
<b>S</b> 20	and Ment is marked aumatic e	욘	Raymond At 19a. Informant's Name/Relationship	igustine Mc( (Type.Print)			s (Street and		larie ural Route Numb		State, Zip Code)	
≥:	<u>_</u> = 5		Estelle A. McCal 20a. Method of Disposition 1 Warial 2 Cremation 3	•		O Woodo Disposition (Na V, crematory or			Baltimor Date		1and 21234 City or Town, State	
Daltimo	Department Important: any injury once.		4 ☐ Donation 5 ☐ Other (Special Signature of Eureral Service Local Control of Eureral Service Local Control of Europe Service Local Control of Europe Service Local Control of Europe Service Local Control of Europe Service Local Control of Europe Service Local Control of Europe Service Local Control of Europe Service Local Control of Europe Service Local Control of Europe Service Local Control of Europe Service Local Control of Europe Service Local Control of Europe Service Local Control of Europe Service Local Control of Europe Service Local Control of Europe Service Local Control of Europe Service Local Control of Europe Service Local Control of Europe Service Local Control of Europe Service Local Control of Europe Service Local Control of Europe Service Local Control of Europe Service Local Control of Europe Service Local Control of Europe Service Local Control of Europe Service Local Control of Europe Service Local Control of Europe Service Local Control of Europe Service Local Control of Europe Service Local Control of Europe Service Local Control of Europe Service Local Control of Europe Service Control of Europe Service Local Control of Europe Service Control of Europe Service Control of Europe Service Control of Europe Service Control of Europe Service Control of Europe Service Control of Europe Service Control of Europe Service Control of Europe Service Control of Europe Service Control of Europe Service Control of Europe Service Control of Europe Service Control of Europe Service Control of Europe Service Control of Europe Service Control of Europe Service Control of Europe Service Control of Europe Service Control of Europe Service Control of Europe Service Control of Europe Service Control of Europe Service Control of Europe Service Control of Europe Service Control of Europe Service Control of Europe Service Control of Europe Service Control of Europe Service Control of Europe Service Control of Europe Service Control of Europe Service Control of Europe Service Control of Europe Service Control of	ify)	Morelar	nd Mem.				Baltimon	<u>re Marylan</u> ral Home, In	
per per	lmpc any			agon		1	York	1,			nd 21204	·
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List onl Immediate Cause (Final	mplications that caused to y one lause on each line	the death. Do n	ot enter the mo	de of dying,	such as cardia	c or respiratory a	rrest,	Approximate Interval Betwee Onset and Dea	en ith
//\	ysicían ⁄ledícal		disease or condition resulting in death)	a. SEPSIS  Due to (or as a	consequence o	f):						
Ex	aminer	<u>.</u>	Sequentially list conditions,	b. ISCHEM	Consequence o							
cuted	nd ransit	Examiner	Sequentially list conditions, it immunes cause. Enter Underlying Cause (Disease or injury that initiated events	C	CONSO JUSTICE O	4.						
os/ou, tificate be executed	hysician ai he burial-t	edical Ex	resulting in death) Last	Due to (or as a	consequence o	f):						
I RECORDS, P.O. BOX by The law requires that the death certific	within 24 hours after death.  To the Funeral Director After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	Fetal death	3 ☐ Ectopic 5 ☐ Other (s					te of delivery onth Day Yea	ar
S, T.	gned by se detac	by Ph	Part II. Other significant conditions		t not resulting in	the underlying	cause given	in Part I.	- III 🕠		ribute to the cause of dear	
ecords law requires	been sig	eted t	RESPIRATORY	FAILURE					1,00		3 Probably 4 Unk	_
Tec	te has bage 2 s	Completed							24a. Was auto perfo	psy prmed?	Were autopsy findings ava prior to completion of caus death? 1 □Yes 2 ☒No	se of
OT VITAL	sertifica setor, p	Be C	25. Was case referred to medical examiner?	Hospital: V			Othor		1 □ Yes eath (Check only o		10163 22110	
OT OF	er this c	n: To	1 Yes 2 No  27. Manner of Death	28a. Date of Injur	nt 2 ER/Out	ime of	28c. Injury a	4 Li Nursing	Home 5 ☐ Resi 28d. Describe	idence 6 Oth how injury occur		
SION	ea.h. or Aftu the fun	catio	1 Natural 5 ☐ Pending 2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	he ·		njury M		s 2 No				
LIVISI allor Atter	s fiter d	Certification:	4 Homicide determine		ry - At home, far . <i>(Specify)</i>	m, street, facto	ry, office		28f. Location ( City or To	Street and Numb wn, State)	oer or Rural Route Numbe	r,
To the Hospital or Attending	24 hours <b>Funera</b> stely fille	edical (	29a. Certifier (Check only one) 1 Certifying I	Physician: To the best of aminer On the basis of and manner state	examination an	, death occurre d/or investigation	d at the time n, in my opi	e, date and place nion, death occ	ce, and due to the curred at the time	cause(s) and m date and place,	anner as stated. and due to the cause(s)	
To the	within To the comple	Mec	29b. Signature and title of certifier	4—		29	c. License r	number			d (Month, Day, Year)	· · · ·
			30. Name an address of person wh	Completed cause of do	eath (Item 22a) /	Type Print)	D4635	56	,	AugusT	04, 2005	1
			KHOSROW TAASS	I. M.D.	7601 0		RIVE	TOWS	ON, MARY	/ /LAND E	1 = 714	
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						PRIGINAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 8 Day **Physician** Kenneth Edward Mullaney 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner auare Hosp Tal Center Kosed more 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, July 7, 5. Social Security Number Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F 220-38-8950 67 Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 🔀 No Director Baltimore Baltimore County Maryland 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21220 U.S.A. 6834 Leslie Road Funeral 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 ∐Yes 2 TXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 □Yes 2 👿 No Specify: Se 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "na any injury or other traumatic even" \*\*\*\* Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) Police Department Detective 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Patrick Mullaney, Margaret Spath ဨ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6834 Leslie Road, Baltimore, Marie Cecelia Mullaney / Wife Maryland 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

11 top Service Corp. 08-07-2009 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Towson, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Juneral Service Licens 1050 York Road, Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Trocordia /Medical Due to (or as a consequence of): Examiner betes if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Typertens

Due to (or as a consequence of): Tenslor sician and burial-trans Hospital or Attending Physician: The law requires that the death certificate be execut P.O. Box 68760, After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Ye's 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 □ Yes 2 No 2 🗆 No 1 □Yes 25. Was case referred to medical examiner?
1 X Yes 2 ☐ No 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. the To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific

State Registrar

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32. Registrar's Signature

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Baltimore Md

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nena Novello 31. Date filed (Month)-Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Rache1 Alice Morgan 2009 8:23 P™ August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Care Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Month, Day, Year)
October 19, 1915 Days Hours 1 ☐ M 2 🕱 F Months Director 261-57-5811 Pennslvvania Usual Residence of Decedent 10h. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Baltimore Baldwin Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 21013 U.S.A. 10 Windy Manor Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1▼JYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ Specify: White 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) Army - Military Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental F Hummel Matthew A. Swaney Helen Mae 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ,us permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra 10 Windy Manor Court, Baldwin, Maryland George Morgan / Son Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 08-05-2009 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Fundal Service Licensee 1050 York Road, Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Vascular LANS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 1€ months? 1 □Yes 2 □No Month 5 Other (specify) P.O. been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋛ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? icate has t , page 2 s certificate 1 ☐ Yes 2 ☐ No of Vital director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Sother (Specify) WSput Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To funeral 27. Manner of D. ath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division Hospital or Attending Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 ☐ Suicide n 24 hours after de te Funeral Directo bletely filled in by tl 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

30. Name and

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address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. ate of Maryland / Department of Health a Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death **Physician** Month Day р м JULY 31, 2009 MINNIE O'CONNOR 930 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GOLDEN LIVING CENTER HAGERSTOWN WASHINGTON If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 M ANF 87 Director NC SEP. 12, 1921 220.22.1411 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes ŽŽ No 28a-f sh notified Director MD WASHINGTON **HAGERSTOWN** 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be in 750 DUAL HWY. 21740 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant I item 27 Is marked other than "natural", or ite 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify WHITE ģ Specify: 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 MINNIE LEE PRICE LAWRENCE BROWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19104 RED MAPLE DR., HAGERSTOWN, MD 21742 SON REX CAMDEN 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 'Department of H Important: If ite any Injury or ot 1 ∑NBurial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) CROWNSVILLE VETERANS CEM. AUG. 4,2009 CROWNSVILLE, MD 21. Signature of Funeral Service Licensee FINK FUNERAL HOME, P.A. MD1452 426 CRAIN HWY. S., GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final iva cirrhose **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) Examiner burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical as the IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2√No the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ca (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street Hagerstown 191021190 SHVA 368 muil 31. Date filed (Month, Day, Year) State 05 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 2009 **Physician** 2310 M /Medical 4b\_City, Town, or Location of Death 4c. County of Death **Examiner** 9. Birthplace (State or Foreign In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Year) 140-20-1278 Director arolina 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Daltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Blac Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Worker Bethleham Stee 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be r and Mental F 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 🕦 🔟 🤈 permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trau Margaret Baltimore, 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State 21. Signature of Funeral Service Licensee MO1553 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) ENCEPHALOPATHY hysician /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, county to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 4 Unknown 1 🗌 Yes 2∏ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 24a. Was an perform Q⊟ No 2 100 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Man f Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 Accident o the Hospital or Attency within 24 hours after death To the Funeral Directors. 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) - Wolfsham Woods Road - MD 21234 10 V State AUG Registrar DHMH 17 Rev 1/2001

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David Reese 09-05996

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JNK UNK	State of Maryland / Department of Health and Mental Hygiene  1-For State Registrar  Certificate of Death Reg. No. 2 0 0	21,99
Physician/ Vledical Examiner	1. Decedent's Name (First, Middle,Last)  2. Date of Death	3. Time of Death 0229 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death University Hospital 4c. County of Death Baltimore	
Funeral Director	Months Days Hours Min 1 / Foreign	nplace (State or ntry Mary (Aug
and show any nce.	III NIA Pratimon	10d. Inside City Limits 1 Yes 2 No
h the Maryland 3a or 28a-f sho totified at once.	10e. Street and Number  10f. Zip Code  10g. Citizen of What Count  21201  U.S.A.	ry?
fter death with I", or items 23 er must be no / Funeral		an Indian, Black,
15-0036 filed within 72 hours after death with the Maryland I Hygiene. d other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once Completed by Funeral Director		dustry Nork
B respective	Leremiah Keese Beverly Keese	
MD and 2 sho salth and 2 sho ra 27 is raumati	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,  19b. Mailing Address (Street and Number, City or Town, State,  19b. Mailing Address (Street and Number, City or Town, State, State, State, State, State, State, State, State, State, State, State, State, State, St	7 21301
<b>⊏</b> 5 5 2 7 1	1 Burial 2 Cremation 3 Removal from State Crematory or other place 4 Donation 5 Other Specify: M+ 2 on Cemetery 8 8 109 Baltimo	~ ~
Balti Departu Importi	22. Name and Address of Facility Howell Function  22. Name and Address of Facility Howell Function  44.00 Liberty Heights Ave, Butto  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as dardiac or respiratory arrest, shock, or heart	Approximate Interval
/Medical Examiner	failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	Between Onset and Death
iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
ecured and ransit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
0, be ex sician surial	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	
). Box 6876 the death certificate by the attending phy ched for use as the Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Da  1 Ves 2 No 9 Unknown  9 Unknown	ay Year
P.O. ires that the signed by the detache	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the significant conditions contribute to the significant conditions.	
Division of Vital Records, P.O. Box 6876 and or Attending Physician: The law requires that the death certificate rather death.  The law requires that the attending phy led in by the funeral director, page 2 should be detached for use as the best filteration: To Be Completed by Physician/M	24a. Was an autopsy prior to co death?  1 ✓ Yes 2 No 1 ✓ Yes	opsy findings available impletion of cause of
Vital hysician: this certiful director,	25. Was case referred to medical examiner? 1 V Yes 2 No  26. Place of Death (Check only one)  Hospital: 1 V Inpatient 2 ER/Outpatient 3 DOA  Other Nursing Home 5 Residence 6 Other:	
ision of Vital Battending Physician: or death. rector: After this certifi by the funeral director. Ication: To Be C	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury Aug 1, 2009 28b. Time of Injury 0140 hrs 28c. Injury at Work? 1 Yes 2 ✓ No 28d. Describe how injury occurred Subject stabbed	
Division o spital or Attending hours after death. neral Director: Aft filled in by the fune Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Local Street 28f. Location (Street and Number or Rura or Town, State) 300 North Paca Street, Baltimore, Morth Paca Street, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore, Baltimore	il Route Number, City d.
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one)  2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated.	
× N	29b. Signature and title of certifier  29c. License number  O.C.M.E.  August 1, 2009	h, Day, Year)
0.0	30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State Registrar	**** *** *** *** *** *** *** *** *** *	

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Physician /Medical Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Motical Eventing must be notified at agine.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	State Registrar						Ce	rtificate o	t Death			Reg. No.			0.7	a of Death
1	. Decedent's Name										Date of De Month リムロムフ	Day		Year		e of Death ; O4AM
	La. Facility Name (If not institution, give street and number)  SINAL HOSPITAL OF BALTIMORE							4b. City, Town, or Location of Death  BALTIMORE				4c. County of Death				
10000				(In yrs. las	Ast birthday    If Under 1 Year   If Under 24 Hrs.   8. Date of Birth   Yrs.   Months   Days   Hours   Min.   1 0 - 1 7 -			9. Birthplace (State or For WEST VIRGINI			RGINIA					
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1	MD.  Oe. Street and Nur  3727 B			₹.		DAI	LTIMO					•	Og. Citizen of What Country?			
3727 BOARMAN AVE.  11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in Armed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates:				ver in U.S.						- 1	14. Race - American Indian, Black, White, etc.  Specify: BLACK					
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1	7. Father's Name	(First, Middle,		College (	1-401-31		ARMY INTELLIGENCE  18. Mother's Name (First, Middle, M DOROTHY BOOKER					, Maiden S				
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	21. Signature 1 £1 23a. Part 1 Enter t	ratt	License	JONA	Hi	D. 1	HIBNE	721-27 N	dress of Facility P N. MONROE	HIL	LIPS I	FUNER	AL E	HOME,	AND Approx Interva	A. 21217 imate Between
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Date More More Secontributed More More More More More More More More	e of deliverent of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of	ery Day  he cause pably find mpletion 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No. 2 No	Year  of death?  Number,  Number,  use(s)

State Registra Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Frank Albert Snyder   4a. Facility Name (if not institution, give street and number)   Atlantic General Hospital   5. Social Security Number   218-60-4466   1 Mm 2 F   53   Yrs.   Months Days Hours Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.   Min.	od. Inside City Limits Yes 2 No
Frank Albert Snyder   July 31, 2009   4a. Facility Name (if not institution, give street and number)   Atlantic General Hospital   4b. City, Town, or Location of Death   Worcester	ace (State or ry) MD  od. Inside City Limits Yes 2 No
Atlantic General Hospital  Serlin  Worcester  Funeral Director  Atlantic General Hospital  S. Social Security Number 218-60-4466   6. Sex 1/1 Mm 2 F 53   7. Age (In yrs. last birthday)   1. Months   Days   Hours   Min.   01/24/1956   Foreign   Foreign   Country   1. Months   Days   Hours   Min.   01/24/1956   Country   1. Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   Days   Months   D	od. Inside City Limits Yes 2 No
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Maintenance  12 Maintenance  13. Father's Name (First, Middle, Last) Charles Anthony Snyder Sr.  14. Father's Name (First, Middle, Maiden Surname) Maria Paradisi  15. Maintenance  16. Maintenance  18. Mother's Name (First, Middle, Maiden Surname) Maria Paradisi  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip	
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Eugene Snyder/Brother 302 Terrysyde Ct. Fallston, MD 210	
20a. Method of Disposition  1 Burial 22 Cremation 3 Removal from State Crematory or other place)  1 Burial 22 Cremation 3 Removal from State Crematory or other place)  1 Donation 5 Other Specify:  20b. Place of Disposition (Name of cemetery, crematory or other place)  1 Donation 5 Other Specify:  21 Signature of Funeral Service Licensee  220. Name and Address of Facility CAFA/Stephen D. Lohring Carlot of Facility CAFA/Stephen D. Lohring Carlot of Facility CAFA/Stephen D. Lohring Carlot of Facility CAFA/Stephen D. Lohring Carlot of Facility CAFA/Stephen D. Lohring Carlot of Facility CAFA/Stephen D. Lohring Carlot of Facility CAFA/Stephen D. Lohring Carlot of Facility CAFA/Stephen D. Lohring Carlot of Facility CAFA/Stephen D. Lohring Carlot of Facility CAFA/Stephen D. Lohring Carlot of Facility CAFA/Stephen D. Lohring Carlot of Facility CAFA/Stephen D. Lohring Carlot of Facility CAFA/Stephen D. Lohring Carlot of Facility CAFA/Stephen D. Lohring Carlot of Facility CAFA/Stephen D. Lohring Carlot of Facility CAFA/Stephen D. Lohring Carlot of Facility CAFA/Stephen D. Lohring Carlot of Facility CAFA/Stephen D. Lohring Carlot of Facility CAFA/Stephen D. Lohring Carlot of Facility CAFA/Stephen D. Lohring Carlot of Facility CAFA/Stephen D. Lohring Carlot of Facility Carlot of Facility CAFA/Stephen D. Lohring Carlot of Facility Carlot of Facility Carlot of Facility Carlot of Facility Carlot of Facility Carlot of Facility Carlot of Facility Carlot of Facility Carlot of Facility Carlot of Facility Carlot of Facility Carlot of Facility Carlot of Facility Carlot of Facility Carlot of Facility Carlot of Facility Carlot of Facility Carlot of Facility Carlot of Facility Carlot of Facility Carlot of Facility Carlot of Facility Carlot of Facility Carlot of Facility Carlot of Facility Carlot of Facility Carlot of Facility Carlot of Facility Carlot of Facility Carlot of Facility Carlot of Facility Carlot of Facility Carlot of Facility Carlot of Facility Carlot of Facility Carlot of Facility Carlot of Facility Carlot of Facility Carl	
4 Donation 5 Other Specify:  21(Sygnature of Funeral Service Licensee - M ) VI (2) 22. Name and Address of Facility CAFA/Stephen D.Lohri	mann P.A
10/1/ Gleen lastules DL. Dalto, i	MD 21286
Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 4	Between Onset and
Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	Death
. Sequentially list conditions,	
if any, leading to immediate Due to (or as a consequence of):	
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the	
1 Yes 2 ✓ No 3 Probable 1 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes 2 ✓ No 3 Probable 2 Yes	
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1 ✓ Yes 2 No 1 ✓ Yes	2 No
25. Was case referred to medical examiner?  1 Ves 2 No   Hospital: 1 Inpatient 2 Ver ER/Outpatient 3 DOA   Other   Other:   Other	
28d. Describe how injury occurred Operator lost control of motor sc	
O be the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of	cooter
28e. Place of Injury - At home, farm, street, factory, office building, etc.  28f. Location (Street and Number or Rural or Town, State)  A Homicide determined determined or Town, State)  (Specify) Major Road / Highway  28f. Location (Street and Number or Rural or Town, State)  MD Rt. 589 S/O MD Rt. 90, Berlin, MD	
determined (Specify) Major Road / Highway MD Rt. 589 S/O MD Rt. 90, Berlin, ME 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifier 4 29a. Certifi	
를 들 볼 다 으 one) 2 🕡 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the c	cause(s)
and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month)	h, Day, Year)
O.C.M.E. July 31, 2009	
30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed Marth. Presidence 32. Registrar's Signature	

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 's Name (First, Middle, Last, 2. Date of Death 3. Time of Death **Physician** DIMMONS /Medical 4b. City Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Mar 8. Date of Birth (Month, Day, Yea Under 9. Birthplace (State or Foreign Social Security Number ge (In vrs. last birthday) **Funeral** Min. 1 ☐ M 2 ▼ F Months Days Director 10d. inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 Tes 2 □ No Director timore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a by Funeral . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐Yes 2 No 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, Item 100 y/Secondary (0-12) College (1-4or 5+) releptone (o. eal Maryland ather's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14146 me/Relationship (Type. Print 19a. Informant's Na Bed Foxo, Baltimore, . Metrod of Blogs

1 □ Burial 2 Cremation 3 □ R

4 □ Donation 5 □ Other (Specify) 3 Removal from State 21. Signature of Funeral Service Licensee NO1553 212 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of ling, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** a. CERVICAL CANCER /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and s the burial-trans Due to (or as a consequence of): Physician/Medical as the t IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months?
1 Yes 2 No Month Year Day 5 Other (specify) P.0. the 9 Unknown 9 Unknown s been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, à 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate 2X No 2 🗆 No 1 □Yes 1 🗀 Yes of Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 ☐ Yes 2 👿 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ျ 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Division Vithin 24 hours after .....
To the Funeral Director: After ..... 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one Nurse Practition remembers stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year)

a.m.

2009

State Registrar

JACKIE JONES,

31. Date filed (Mo

2300 DULANEY VALLEY RD.

CRNP 32. Refistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5

park

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar Co	ertificate of	Death	Re	eg. No. 20	9	24998	
	Physici	an	1. Decedent's Name (First, Middle, Last) Lloyd Thomas Stine III			2. Date of Death Month August	_	Year	3. Time of Death 4:00 A M	
- Sec	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, o	or Location of Death		4c. County o	f Death	4.00 A	
of the			Gilchrist Center	Towson				Baltimore		
	Funeral Director		5. Social Security Number 217 62 0638  Usual Residence of Decedent  6. Sex 1	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Pay July 14 19	9 <b>5</b> 3'		place (State or Foreign htry) Imore ,Maryland	
	Maryland a-f show	ctor	10a. State 10b. County 10c. City, Town or Baltimore Baltimore					1	1 ☐ Yes 2 No	
	th with the 23a or 28	Funeral Director	10e. Street and Number 7710 Old Harford Road	10f. Zip Code 21234	10	10g. Citizen of What Country? USA				
900	be filed within 72 hours after death with the Maryland that Hygiene.  do other than "natural", or items 23a or 28a-f show event, the Modical Examinar must be notified at		11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☑ Yes 2 □ No If Yes, Give Year or Dates: Vietnam	3. Was Decedent of I If Yes, specify Cub 1 □Yes 2 No		pecify Yes or No- Rican, etc.)		, White,		
1215-(	vithin 72 ho ene. than "natu	To Be Completed by	(Specify only highest grade completed) (Gin	cedent's Usual Occup ve kind of work done on DO NOT use retire ce <b>Technici</b>	during most of work d)	ding	16b. Kind of Bus Security			
Baltimore, Maryland 21215-0036	al Hyg other		17. Father's Name (First, Middle, Last) Lloyd Thomas Stine II			e (First, Middle, N	<u>-</u>			
, Mary	and 2 should be afth and Mental 27 is marked of traumatic ever traumatic ever		19a. Informant's Name/Relationship (Type. Print)  Karen F Stine (Wife)  19b. Ma 7710	iling Address (Street 01d Harford	and Number or Rud Road Ba	ral Route Number, L <b>timore</b> ,Mar	City or Town, S yland 212	itate, Zip 234	) Code)	
imore	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic e once.		20a. Method of Disposition  1 □ Burial 2 ☑ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)  20b. Place of Discemetery, or Metro Crem	position <i>(Name of</i> rematory or other planatory Inc	August 3 2		Paltimore,	•		
Balt	permit. Depart Import any Inj		21. greature of Funeral Service Deensee	22. Name and Addre Lassahn Fund 401 Belair F	ess of Facility eral Home Ir Poad Baltim	nc ore,Marylar	nd 21236			
	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease or complications that caused the death. Do not explose, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, hearing to immission cause. Enter Underlying Cause (Disease or injury that initiated events	nall cell			est,		Approximate Interval Between Onset and Death UNKNOWN	
68760,%	ertificate be executed ling physician and e as the burial-transit	Medical Certification: To Be Completed by Physician/Medical Exar	resulting in death) Last  C.  Due to (or as a consequence of):							
P.O. Box (	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit			B□ Ectopic pregnand □ Other (specify) _	gy		23d. Date Mon		ery Day Year	
Division of Vital Records, P.	uires that n signed b Id be deta		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause giv	en in Part I.	23e. Did tob			he cause of death?	
	The law requir ate has been si page 2 should i					24a. Was ar autops perform 1 □ Yes 2	v br	ior to co	opsy findings available impletion of cause of	
	Iclan: certific ector,		25. Was case referred to medical examiner?  1. Types 2. 200 No.   Hospital:   Low		h (Check only one	e)		11 - 1		
	To the Hospital or Attending Physician: The law within 24 burus after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		1 Yes 2 No roughtat. 1 Inpatient 2 ER/Outpati 27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 2 Accident roughtation 2 ER/Outpati	of 28c. Inju		ome 5 ☐ Reside 28d. Describe ho			MOSPICE	
Divisi			3   Suicide 6   Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)				Street and Number or Rural Route Number, rn, State)			
	ne Hospil n 24 hour ne Funeri		29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, de control on the basis of examination and/or and manner stated.	ath occurred at the ti investigation, in my	ime, date and place opinion, death occu	, and due to the carred at the time, da	ause(s) and mar ate and place, a	ner as s	stated. o the cause(s)	
	To the within To the Comp.		29b. Signature and title of certifier	29c. Licens	se number 5 4195	3	9d. Date signed	(Month, 2 - (	Day, Year)	
	1041	1	30. Nume and address of person who completed cause of death (Item 23a) (Type	e, Print)	o Colo	mhia	MD	21	044	
	Sta Registr		31. Date filed (Month, Day, Year) AIIG 05 2009  Server 32. Registrar's Signature	P						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August Physician 03. 2009 4:40 AM Juliana Reese Schamp /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Edenwald Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 27,1923 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral Months Days Hours Min 1 □ M 2 X F Director 297-16-1750 Ohio 86 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shamprizent: If Item 27 is marked other than "natural", or items 22a or 28a-f shamp injury or other traumatic event, Ite Medical Examination and process. 1 ☐ Yes 2 X No Director MD Towson Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number #503 21286 USA 800 Southerly Road by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) State of MD / Dept. of Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ <u> Health&Mental Hygiene</u> <u>Administrator</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph D. Reese Elizabeth Meek ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 800 Southerly Road #503; Towson, MD 21286 Homer W. Schamp husband 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 4 ☐ Donation 5 ☐ Other (Specify) 8/7/09 ton. Service Corp.: Towson, MD e f Funeral Service License 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on with line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** >20years HU105014 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Se wentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of). The law requires that the death certificate be executed attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Dav Year 5 Other (specify) signed by the a d be detached fo 1 □Yes 2 No 9 🗀 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 🗆 Yes 2**X** No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy certificate nrive! al or After...
urs after death.
.eral Director: After this ceru...
.erad in by the funeral director, pa 1 ☐ Yes 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature any title of certifie

12

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

09-06027 Cortez Smith

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rtez Smith		State of Maryland / Department of Certificate of		ygiene Reg.	No. 201	0 2500
Physici edical Exam	an/	1. Decede It's Name (First, Middle, test)		2. Date of Death Month	Day Year	3. Time of Death
FUICAI EXAIII	mei		b. City, Town, or Location of Death	August 2, 20	4c. County of Death	
Funcial		University Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Baltimore  If Under 1 Year   If Under 24Hrs	s. 8. Date of Birth	MM/DD/YYYY) 9. Birt	hplace (State or
Funeral Director		213-33-4772 1XM 2 F	Months Days Hours Min	-	Foreig	
Ą		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Locati	000			10d. Inside City Limits
nd show any ce.	ī	MD Baltimore Windson	A B C b			1 Yes 2 No
Marylar - 28a-f	Director	10e. Street and Number	10f. Zip Code	109	. Citizen of What Cour	ntry?
vith the s 23a or	al Di	3614 Hallam Court  11. Marital Status  12. Was Decedent Ever in U.S. 13. Was	s Decedent of Hispanic Origin? (S	pecify Yes or No-	USA 14. Race - Ameri	can Indian, Black,
death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral	1 Never Married 2 Married Armed Forces? If You Yes 2 No	es, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
urs after tural",	by	3 Widowed 4 Divorced If Yes, Give Year 1  or Dates  15. Decedent's Education (Specify only highest grade completed) 16a. Deceden	Yes 2' No specify: t's Usual Occupation (Give kind of	work done 1	6b. Kind of Business/I	ndustry
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene with a free death with the Maryland and Mental Hygiene "matural", or items 23a or 28a-f she ratic event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ost of working life. DO NOT use ret	tired)	NIF	
5-0036 iled within 7 Hygiene. I other than	Com	7 Father's Name (First, Middle, Last)	18.Mother's Nam	e (First, Migroye, Ma		
ID 21215-00; should be filed with and Mental Hygiene. 7 is marked other the matic event, the Med	Be	Nonte Smith  190. Informant's Name relationship (Type, Print)  19b. Mailing	Address (Street and Number or	en tra	City or Town State	Zin Code) <b>3.1.7.1.1.1</b>
MD 2 d 2 shoul lth and N n 27 is n	70	Aileen Fratt (Mother) 2614	Hallam Co	urt. h	indsor M:	1. MD 277
ore, ges I an of Hea If iten ther tra		1 Burial 2 Cremation 3 Removal from State Crematory or oth		B   09	20c. Location - City or Woodlaw	Town, State
Baltimore, permit. Pages La Department of Hic Important: If ite injury or other ti		4 Donarion 5 Other Specify: Wood Gu. 21. Signature of Funer Service Ligansee / 22. N	on lemetery of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later of later	eene tra		wices
<b>m</b> 80 E ii	_	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the		Vati Pi	Ke (Z12	29) Approximate Interval
Physician /Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Gunshot Wound of Chest	le mode of dying, such as cardiao	or respiratory arres	n, orioon, or ricare	Between Onset and Death
xaminer		or condition resulting in death)  Due to (or as a consequence of):			-	
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause				
cuted and transit	Exam	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	0.50			
O, As be executed sician and burial - transi	dical	UNPENDED X AMENDED #1 as noted pe	r ME g894 8/5/09	TT		
	ıw	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fe	tal death 3 Ectopic pregn	nancy	23d. Date of deliver Month	y Day Year
Box 6876( death certificate the attending physical for use as the b	Physician/M	past 12 months?	her (Specify)			
ires that the de signed by the de detached f	/ Phy	Part II. Other significant conditions contributing to death but not resulting in the	inderlying cause given in Part I.		acco use contribute to	
S, P puires th puires th on signe and be de	ed by			1 Yes		bably 4 Unknown
of Vital Records, ng Physician: The law require the this certificate has been simmed director, page 2 should b	ı =			autops perform	y prior to ned? death?	completion of cause of
tal Recieium: The certificate	e Co	25. Was case referred to medical	26.Place of Death (Check	1 Yes 2 k only one)	No 1 ✓ Y	es 2 No
'Vita Physicia r this ce al direc	To Be	examiner?  1 Ves 2 No  Hospital: 1 Inpatient 2 ER/Outpatient			Residence 6 Othe	or:
ion of tending Pheath.		27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Monits, Day Year) Aug 2, 2009  1300 hrs	njury 28c. Injury at Work?  1 Yes 2 ✓ No	Subject shot	ow injury occurred	
Division pital or Attendio ours after death.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street	et, factory, office building, etc.	or Town, Sta	ate)	ural Route Number, City
lospital Hours a Juneral		4 Homicide determined (Specify) Front of Residence  29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occur	rred at the time, date and place, an	<u> </u>	Street , Baltimore, N	
Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Functal Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the t	Medical	one) 2 Medical Examiner: On the basis of examination and/or investiga and manner stated.	tion, in my opinion, death occurred		nd place, and due to the	he cause(s)
- F > F 0	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Mo	onth, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a)	3.3.11121			
			et, Baltimore, MD 21201		· · · · · · · · · · · · · · · · · · ·	
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